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ABSTRACT

The Child Study Center (CSC) program provides diagnostic, prescriptive, and consultative intervention services to elementary and junior high school students with serious learning problems. Because of the multi-causation factor present in children with severe learning problems, the CSC concept involves an interdisciplinary team approach which focuses on the whole child in a single referral setting. Major activities include the following: collecting data on the student; conducting an in-depth, interdisciplinary study; developing composite diagnoses and prescriptions for establishing remedial plans; providing short term diagnostic treatment for determining the validity of diagnostic and prescriptive reports; and conducting activities to facilitate adequate implementation of treatment plans. The educational diagnostician, psychologist, school social worker, and speech pathologist are each responsible for an individual report of observations, findings, general recommendations, and specific instructional or behavioral suggestions. Team staffings and consultations are held to synthesize the results of individual reports into a composite whole. In addition to remediation in academic and communication skills, individual or group counseling for children and/or their parents is provided to enhance children's motivation to learn and behave more productively. (Appendixes include strategies for enhancing psychological evaluations; a listing of evaluation instruments; some reflections on the group remedial program; classroom guidelines for facilitating learning; and sample forms, records, and reports.) (SBH)

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GENERAL INTRODUCTION

The Child Study Center Program*

The Child Study Center (CSC) is an innovative program of the Pinellas County, Florida, Pupil Services Demonstration Project, a validated, ESEA Title III project.

The purpose of the Child Study Center is to provide the diagnostic, prescriptive and consultative intervention necessary to assist referred students with serious learning problems experience success in school.

The CSC was established in 1971, as the delivery system to fulfill a need for additional services to children in the Pinellas County school system. At that time, available evidence indicated that approximately 8% of Pinellas County elementary school students were experiencing severe learning problems and were not receiving adequate assistance from existing programs. Furthermore, it was found that approximately 5% of the students in the densely populated area of Southeastern St. Petersburg (the target area for this project) were experiencing multiple learning problems which were preventing the children from deriving optimal benefit from their school experience.

The CSC project serves students who attend 20 elementary and junior high schools (Grades K-8) in the target area of lower Pinellas County, which is 100% urban. Approximately 90,000 persons (including 15,000 students) live in this area of Pinellas County which has the highest population density of any county in Florida.

Because of the multi-causation factor present in children with severe learning problems, the CSC concept was developed on the premise that the solution to such problems lies in an interdisciplinary team approach which focuses on the whole child in a single referral setting. These troubled children need to receive comprehensive, in-depth diagnostic and remedial services so that they can become more effective and efficient learners.

During the past three years, the Child Study Center has developed an intervention program designed to meet critical learner needs, and embraces the disciplines of education, psychology, social work, and speech pathology in implementing a team approach to aiding the educationally troubled child.

Major activities of the Center's study of each child include: data collection; conducting an in-depth, interdisciplinary study; developing composite diagnoses and prescriptions for establishing remedial plans; providing short-term diagnostic treatment for determining the validity of diagnostic and prescriptive reports; and conducting activities to facilitate adequate implementation of recommended treatment plans. The CSC is housed in All Children's Hospital, and is able to obtain pediatric, neurological and ophthomological examinations for needy children through the Out-Patient Clinic. Additional medical and psychiatric services and consultations are contracted for as needed.

*Presented by Diana G. Bryant at the International Reading Association Annual Convention, May, 1975.

Since it is necessary to gather information that relates to all facets of the learning process, data collection activities are a crucially important aspect of the entire study. A CSC staff member is assigned as coordinator of each case and is responsible for obtaining all available information on previous services provided by school personnel and community professionals. The child's teachers' reported perceptions of behaviors at school and a classroom observation by the case coordinator provide insight into an understanding of the child's problems as well as the nature of teacher-child relationships.

The Center social worker arranges an intake conference with the parents who assist in further defining the nature of the child's problems by providing information as to the child's development, the family history and current family dynamics. The data collection procedures normally precede the formal evaluation of the child at the Center.

The evaluative aspects of the Center study is the heart of the program for staff diagnosticians and consumes an intensity of effort, if not a major portion of time. Each child participates in evaluative activities with the psychologist, speech pathologist and educational diagnostician.

The psychological assessment includes testing and observation to determine intellectual functioning, personality adjustment, social-emotional development, and possible neurological dysfunctioning.

In the evaluative process of the Center the educational diagnostician is responsible for assessing the learning aptitude and academic functioning of the student. Specific areas of examination are: the functioning of the learning modalities; the preferred learning style; vision acuity and visual perceptual development; visual-motor integration; reading, spelling, writing, language development, math and study skills. Data from test results and observations are used in determining the present grade level functioning in each area, but more importantly, in analyzing the specific learning and academic needs of the student so that an efficacious instructional program can be devised.

The communication evaluation encompasses the area of speech, language and hearing. Specific skills which are examined include: articulation, fluency, vocal production, oral mechanism, vocabulary, syntax, grammar, auditory acuity, and auditory perception. The general purpose of this phase of the diagnostic process is to determine whether a communication dysfunction exists, and to what extent it interferes with the child's ability to learn.

Formal evaluation time averages 9 to 12 hours. Each diagnostician is responsible for an individual report of observations, findings, general recommendations and specific instructional or behavioral suggestions. Team staffings and consultations are scheduled to synthesize the results of individual specialists into a composite whole. The composite reports are comprehensive, specific and action-oriented. The reports pin-point specific problems relating to learning skills and behaviors of the child, and suggest strategies by which parents, teachers and significant others can intervene successfully. The diagnostic findings are reported to school personnel, parents and involved community professionals in person and in writing.

Dialogue and consultation are ongoing processes within the team, with related workers and with the family. Consultation encompasses all delivery aspects of service to the child. The study, in itself, only becomes useful when it is meaningful and acceptable to all those who educate the child. Therefore, consultation takes many forms, such as: intra-staff meetings; pre-referral consultation; crisis intervention; short-term consultations; medical consultation. Two of the more important consultative efforts include: (1) consultation among Center staff and involved school personnel during and following the Center study to discuss findings and plans for the child and, (2) consultation with the child's parents to maintain their support and involvement.

Remedial efforts are designed to assist the child improve his learning and communication skills as well as increase his frequency of productive social behavior. A major objective of CSC efforts is to monitor and modify the learning process so the child can individually experience feelings of success at school and home.

Center team members participate in the remediation process directly through short-term diagnostic teaching and therapeutic treatment, or indirectly by consultation with classroom teachers, speech therapists, learning disabilities teachers, and other available school personnel such as school counselors and psychologists. CSC staff members are also available to aid in the implementation of the prescriptive programs by demonstrating applicable methods and materials, by providing recommended materials, and by acquiring, training and supervising volunteer tutors.

In addition to remediation in academic and communication skill areas, individual or group counseling for children and/or their parents frequently enhances the child's motivation to learn and behave more productively.

Obtaining treatment or correction of found physical/neurological impairment is another aspect of the total remedial strategies for some children.

An average of 34 hours of services is provided for each referred child; however, each case remains open and receives continued follow-up until school or home indicates that no further help is needed.

The Child Study Center, then, utilizes an interdisciplinary team approach in providing a comprehensive evaluation of children who are exhibiting behaviors indicative of multiple-problems which are impeding learning. Implementation of the composite remedial strategies is achieved through direct contacts with the learner, but primarily through consultative relationships with the significant others in the systems within which a child must function. The exchange of information and the active cooperation among CSC, school, home and community resources is the key to providing services which lead to successful experiences for referred children.

The success/effectiveness of the Child Study Center program has been documented by quantitative statistical procedures implemented in evaluating four objectives. The learner objectives for children following 6 months intervention from the Child Study Center were that participating children will evidence significant improvement in:

1. cognitive development - as measured by the performance on specified sub-tests of the Wechsler Intelligence Scale for Children (WISC).
2. learning aptitude - as evidenced by performance on specified sub-tests of the Detroit Tests of Learning Aptitude (DTLA).
3. oral reading achievement - using the Gilmore Oral Reading Test.
4. mental and physical health functioning - as evidenced by teacher and parent ratings based on observation.

Criterion for objectives #1, 2 and 3 was a statistically significant ($p < .05$) difference between pre- and post-tests, in favor of the post-test performance on the specified instruments.

For Objective #4, criterion was that 70% of the responses to items on relevant sub-scales of the Teacher Rating Scale (TRS) and Parent Rating Scale (PRS) indicate that CSC participants will have been rated as either maintaining or increasing their frequency of appropriate behavior.

Not all children referred to CSC were included in the evaluation design. Those excluded were children referred too late to have post-test data collected, or who left the target area before post-testing. Also, the number of participants involved in the evaluation varied on Objectives #2 and 3, depending on the number initially scoring significantly below average on pre-tests.

Since there was no "control" group available against which the expected gains could be tested for significance, comparisons were made against test norms. Based on the low pre-test scores received by referred children, it was observed that they had been maintaining below average progress.

Standard scale scores (corrected for age at time of testing) were available for the WISC sub-tests (Objective #1) and were used to determine if significant gains were obtained. In Objectives #2 and 3, the DTLA and Gilmore sub-tests yielded age and grade-equivalent scores. Since maturation or normal achievement gains would be expected in the referred children without intervention, it was decided to test for the significance of score gains by requiring them to be statistically significantly greater than the number of grade/age units which had elapsed between pre- and post-testing. Thus, the objective criterion required the gains to be significantly greater than the gains made by average children.

For Objective #4, the locally developed Teacher Rating Scale (TRS) and Parent Rating Scale (PRS) were used to obtain pre-post behavioral indices. The pre-rating scales were sent to the teacher and parent at the time of the child's referral, and again approximately five months later. The validity of both the TRS and PRS is content in nature. The instruments were developed by the Child Study Center. All items are

criterion referenced in the sense that they are descriptions of behaviors whose frequency is easily observable. Using Cronbach's Alpha, internal reliability estimates for the TRS and PRS are .91 and .84, respectively.

The findings for Objectives #1, 2, 3 and 4 follow:

1. Objective #1 - The mean gain scores between pre- and post-tests on 5 sub-scales of the Wechsler Intelligence Scale for Children were analyzed using a paired difference t-test of significance. The gains made on all 5 sub-tests studied were statistically significant at or beyond the .05 criterion level specified. See Table 1. These findings are educationally significant because the gains were made in important areas of cognitive development as measured by an instrument with high predictive validity for achievement in school.

2. Objective #2 - The mean gain scores between pre- and post-tests of 4 sub-tests of the Detroit Tests of Learning Aptitude were analyzed using a paired difference t-test of significance. The gains made on 3 of the 4 sub-tests were significant at or beyond the .05 criterion level specified. One sub-test failed to reach significance by .04 of a point. See Table 2. Since the score gains occurred in essential areas important to academic success, as measured by a valid and reliable instrument, these findings have important educational significance.

3. Objective #3 - The mean gain scores between pre- and post-tests of the Comprehension sub-test of the Gilmore Oral Reading Tests were analyzed using a paired difference t-test of significance. The gains were significant beyond the .05 criterion level specified. See Table 3. Since reading skills are fundamental for success in school the educational significance of this finding is evident.

4. Objective #4 - The pre- and post-ratings for subjects on each item of the Teacher Rating Scale (TRS) and Parent Rating Scale (PRS) were analyzed in order to determine the percentage of responses within each sub-test indicated maintenance or improvement of a given behavior. Since a criterion reference of 70% was established for objective attainment, statistical significance is not applicable. The TRS results exceeded the criterion level on all 5 sub-scale areas. See Table 4a. The PRS results exceeded the criterion level on both sub-scale areas. See Table 4b. These results are evidence that participants have maintained or improved their mental and physical functioning. The educational significance is that as a child exhibits behaviors indicative of improved mental and physical functioning, he more optimally benefits from learning experiences.

The project evaluator, who completed the analysis of all data, is Jeffrey Moore, doctoral candidate in the University of South Florida's Educational Research Program. The development of evaluation designs and the selection of appropriate statistical techniques were done with consultation from the professional staff of the USF Educational Research Department, Dr. Joe Mazur, Department Head.

Table 1 - Mean gain scores between pre- and post-tests of sub-scales of the Wechsler Intelligence Scale for Children using data from 1971-74.

WISC Sub-tests	N	Mean Difference (scale score)	Variance of the mean difference	Hypothesized Difference	t-value
Arithmetic	65	.62	2.40	-0-	3.20**
Digit Span	61[1]	.46	2.25	-0-	2.39*
Picture Comp.	41[1]	.83	4.80	-0-	2.42**
Picture Arr.	61	1.05	3.51	-0-	4.37**
Coding	66	1.45	4.01	-0-	5.90**

Table 2 - Mean gain scores between pre- and post-tests of sub-tests of the Detroit Tests of Learning Aptitude using data from 1971-74.

Detroit Sub-tests	N	Mean Difference (in months)	Variance of the Mean Difference	Hypothesized Difference[2] (in months)	t-value
Aud. Unre. Words	52	16.63	452.08	5.27	3.85**
Aud. Rel. Syll.	53	12.83	172.22	5.26	4.20**
Vis. Att. Letters	29[1]	9.38	180.32	5.24	1.66n.s.
Oral Dir.	45	10.56	275.93	5.18	2.17*

Table 3 - Mean gain score between pre- and post-tests of sub-tests of the Gilmore Oral Reading Test using data from 1971-74.

Sub-test	N	Mean Difference (tenths of gr.)	Variance of Mean Difference	Hypothesized Difference (tenths of gr.)	t-value
Comprehension	40	.9	1.45	.53	2.19*

[1]Not given 1971-72 school year

[2]Calculated from average elapsed time between pre- and post-tests

*$p < .05$ **$p < .01$
n.s. not significant

Table 4a - Results of Analysis of pre- and post ratings on the Teacher Rating Scale (TRS).

TRS Sub-scales	Percentage reported as having maintained or improved behavior
General Academic	75.2%
Specific Academic	72.9%
Mental Health	71.9%
Physical	70.5%
Social	74.7%

Table 4b - Results of analysis of pre- and post ratings on the Parent Rating Scale (PRS).

PRS Sub-scales	Percentage reported as having maintained or improved behavior
Social/emotional	86%
Physical	96%

PROVIDING HELP FOR JAY: IMPLEMENTING AN INTERDISCIPLINARY APPROACH FOR AN EDUCATIONALLY TROUBLED CHILD*

The Child Study Center (CSC) serves children experiencing problems which interfere with and impede learning. The Center attempts to diagnostically study potential problem causes in the areas of learning skills, emotional and physical behaviors, communication patterns and family systems. This multi-facet approach frequently identifies a variety of strategies for helping referred children. The case study of Jay is presented to highlight an interdisciplinary approach for the educationally troubled child as implemented by the CSC.

Jay, an eight and one half year old fourth grader, was described as an atypical child with no predictable pattern to his behavior. His behavior alternated in the classroom between excessive sleepiness and lethargy on the one hand to extreme hyperactivity on the other. Jay's classroom teacher cited the following: crawling or wandering aimlessly around the room; not understanding simple directions; not participating in class activities; hitting other children at random; neither able to function with paper and pencil nor to express himself verbally; and unable to read pre-primer material.

Since Jay was a patient of the Out-Patient Clinic at All Children's Hospital, staff members of the Child Study Center began to reach out to the Hospital's medical personnel to gather relevant data about Jay. Concurrently a classroom observation was arranged.

Jay was born prematurely weighing less than five pounds, was slow in developing and needed medical attention until he was about four years old. The medical data also indicated a trauma of unknown origin at the age of three with a resulting encephalopathy. E.E.G. evaluations had led to the recommendation to place Jay on anticonvulsant medication. Through consultation with medical personnel at the hospital and after a series of tests run to determine barbiturate level, Jay's dosage of phenobarbital was reduced and combined with ritalin in the morning before school.

The Child Psychiatrist at All Children's Hospital was asked to consult on Jay's case. He further provided Jay's family guidelines for dealing with Jay's nocturnal enuresis.

The Stanford-Binet, Detroit Tests of Learning Aptitude, the Bender Visual-Motor Gestalt and other instruments were used to assess Jay's intellectual potential and identify clues to his learning and behavior problems. The pattern with the use of the Binet showed a "normal" spread, with a basal age of 7 and the failure level at 11". Jay's strengths were in the area of general comprehension, visual motor ability and arithmetic reasoning. His deficits, which were very marked, were in the areas of memory and concentration, vocabulary and verbal fluency, and judgement and reasoning. The results of the Detroit Tests were parallel to the Binet findings. Jay's performance on the Bender showed at least a three year lag relative to expectations for his age. Tests involving the visual avenue for receiving information revealed deficits in visual attention span, discrimination, and association. Severe limitations were evidenced in the auditory avenue.

*Prepared by Joy Landau, Learning Specialist at the Child Study Center.

Jay was found to have a slight articulatory difficulty characterized by substitutions which were primarily dialectical in nature. Jay's receptive language was normal, but expressive language was somewhat impaired, primarily through the syntactical avenues.

An overall profile indicated that Jay was performing at a beginning 1st grade level and that he had severe perceptual limitations which impeded academic progress. Diagnostic findings pointed to a need for amelioration in the following areas: basic academic skills; visual discrimination, memory and sequencing; auditory memory and sequencing; and perceptual abilities in eye-motor, figure ground, form constancy, position in space, spatial relationships, body awareness, and directionality.

The composite report was taken to the school by the case coordinator who discussed its content with all school personnel working with Jay. The classroom and learning disabilities teachers were provided guidelines for behavioral management and outlines of suggested activities in specific areas of visual and auditory perception and body coordination. The school counselor, our contact on this case, helped to keep the lines of communication between the school and Center open and meaningful.

In the diagnostic treatment sessions at the Center, attempts were made to gain insights into how Jay responded most effectively. Each insight was hypothesized for testing, and if valid, was utilized in future sessions and passed on to school personnel.

Within the remedial sessions, Jay's ability to attend, remain on task, and perform efficiently was supported through techniques of behavior modification. Each morning Jay selected from a price list, the item he wanted to earn. He was informed of the points necessary to earn this item and given a piece of masking tape. Whenever Jay responded attentively, followed directions, or achieved a particular goal, he was praised verbally and told to give himself a point, which he tallied on the tape. When he earned the required points he received the object of his choice. In a few months, movement was made from (1) using small candies to reward immediately each point of positive behavior, to (2) keeping track of points with a pegboard and receiving candy at the end of the activity period, to (3) moving away from literal and immediate food toward a delay of gratification and more mature rewards.

Jay's parents moved from seeing him as a "special" child who must be overprotected to a child needing a sense of achievement through accomplishment. The school no longer viewed Jay as a candidate for a "special" school but provided collaborative assistance as long as Jay continued to show progress and growth. Once a child who "couldn't follow simple directions and would get lost reaching the restroom", Jay became able to follow multi-dimensional directions with frequent successes. Jay learned to read by the VAKT method and/or sound blending. Although he was still restless and easily distracted at times, his ability to stay on task significantly improved.

There is no magic solutions for educationally troubled children like Jay. However, successful outcomes, evidenced by enhanced functioning intellectually, academically and behaviorally, have been achieved by the CSC intervention program which implements an interdisciplinary approach.

AN INTERDISCIPLINARY APPROACH TO LANGUAGE AND LEARNING DISABILITIES*

The Child Study Center provides services to pupils who exhibit multiple problems with neurological, physical, social, familial and emotional etiology that are of primary influence on learning. Center services are not limited to any specific socio-economic level nor type of problem. The children seen are in trouble academically, usually socially, often medically. Many of the children exhibit varying degrees of language dysfunction in combination with specific learning disabilities.

Evaluation at the Child Study Center is a dynamic process with a comprehensive orientation at every level. Initial intake procedures include obtaining background information from all available sources, classroom observation and parent interview. Each team member employs his specific area of expertise to structure an individualized assessment context which is relevant to each child's situation. A team staffing is held to review results and compile findings, after which a composite report of findings, diagnosis, recommendations and educational prescriptions is written. Conferences between the Center staff, school personnel and parents are scheduled to maintain open lines of communication between all aspects of the child's environment and to establish a methodology for effecting remediation.

To illustrate more specifically CSC's approach to the language/learning disabled child, two case histories from the Center files are briefly summarized.

The first case study is Mike, a 10-year old male. Mike is the youngest son of older parents. Since Mike's father is permanently disabled and the family is large, the economic status is low. His referral cited extremely low academic work, reversals in writing, reading and speech problems. Two years previous to this referral, Mike had received a psychological evaluation and speech therapy for articulatory deviancies through school-based services. He was subsequently transferred to a different school and received no follow-up on recommendations that had been made.

When evaluated at the Child Study Center, psychological findings indicated that Mike's intellectual functioning was in the average range with cultural deprivation evident. His speech at that time was adequate. Dental hygiene appeared non-existent. Both syntax and vocabulary were ar a 6-to-7 year level. Deficits appeared in auditory figure-ground and conceptualization skills. Visual perception was also dysfunctional. Some visual-motor problems were found. The kinesthetic modality appeared to be intact. He was reading at a pre-primer level. Medical examination yielded essentially normal findings.

Center recommendations were:

1. Diagnostic instruction with CSC speech pathologist to discover an efficient remedial approach to auditory perceptual dysfunction.
2. Placement with school learning disabilities specialist and speech clinician for a coordinated language and learning skills program using a Visual-Auditory-Kinesthetic-Tactile approach.
3. Consultation with school personnel to review materials and techniques.

*Presented by Linda H. Leeper at the American Speech and Hearing Association Annual Convention, 1974.

4. Follow-up with home in obtaining financial aid and health care, including dental services.
5. Involvement of Mike in a relationship with a supportive male.

A review of case status six months later revealed:

1. A program for remediation of auditory conceptualization skills had been successfully completed.
2. Mike was reading in Book 4 of the Merrill Linguistic series.
3. The classroom teacher expressed many positive attitudes toward his progress.
4. Mike was verbal concerning his successes and abilities.
5. He has established a positive relationship with a young male staff member at CSC and was enrolled at a local youth center.
6. He had received dental hygiene care and instruction through a junior college clinic and had several teeth filled through the county health department dentist.

A second case deals with Mary, a 12-year old female whose referral stated that she had always had academic problems, and had received some special reading help in the primary grades. Mary was not a behavior problem. The family had been referred to an optometrist when she was in 1st grade.

During evaluation at the Center, Mary was overly verbal and obviously anxious. Psychological profiling revealed a girl experiencing frustration and developing a negative self-concept. Intellectual functioning appeared in the low average range. Although her verbal expressive skills seemed adequate, severe auditory recall and conceptualization deficits were found. She, particularly, had difficulty in perceiving sound changes and visually encoding them. Her visual recall skills were average. A severe deficit in work attack techniques was recorded. This 7th grade child was functioning at a 5th grade instructional level.

Recommendations included:

1. Placement with school-based speech clinician to work in close coordination with classroom teachers (no learning disabilities teacher was available at this school). This work included designing of recall exercises for use in classroom and at home, and use of Auditory Discrimination in Depth program (Lindamood: Teaching Resources).
2. Vision re-check by optometrist.
3. Increased use of visual cues whenever possible in the classroom.
4. Repetition of directions and assignments given orally by classroom "buddy" or through the use of a tape recorder.

Post-test results six months later yielded the following gains in performance:

1. Huelsman Word Recognition: +1.5 grade level.
2. Gilmore Oral Reading - Accuracy: +1.0 grade level.
   Comprehension: +2.0 grade level.
3. Detroit - Auditory Attention - Unrelated Words: +2.0 years.
   Related Syllables: +2.0 years.
   Visual Attention: +2.5 years.
4. Goldman-Fristoe-Woodcock Test of Auditory Discrimination: a gain of more than 20 percentile points.
5. Lindamood Auditory Conceptualization Test: +2 grade levels.

The children served are multi-problemed. Rather than focusing upon the remediation of a single learning blockage, the Center studies a combination of factors that may overtly result in educational dysfunction.

Although each team member maintains his discipline's orientation toward each child, he develops an ecumenical attitude toward problem solving. We strive to find relationships between individual findings. We search for commonalities and consider the chronology of events and behaviors. We attempt to combine diagnostically, both facts and professional insight in order to arrive at viable solutions.

These solutions involve a coordination of effort between Center, home and school. Often, communications among these areas of the child's environment have been disturbed or, at best, sporadic. We frequently meet frustration, distrust or apathy in the attitudes of each institution toward the other. However, barriers to communication can be overcome by demonstrating a sincere desire to help children. Joint conferences may be held to discuss areas of mutual concern and to consider specific and concrete methods to alleviate problems.

The result of this interdisciplinary effort is a process that we have labeled synergism - a whole greater than the sum of its parts. Factors influencing the child, both past and present, are organized into one central file. In comprehensive staffings, these factors are considered and a composite approach tailored for each individual child is derived. Due to this centralization, sustained follow-up is possible. One coordinator, who has been exposed to the gestalt of the case, can deal with all aspects of on-going remedial efforts. Obviously, the benefits of this approach to the participating professionals are great. One gains an expanded view through an awareness of areas outside one's own specialization. Through exposure to all facets of case involvement, we can develop a solid orientation as to our role within the youth serving community.

CENTER ACTIVITIES

PROGRAM PROCEDURES/DATA COLLECTION

The Child Study Center has been operationally developed with special concern for maintaining clear and functional lines of communication with the diagnostic, prescriptive and remedial resources in individual school settings. The following is a description of how a referral is processed from the teacher's classroom to the Child Study Center and how background data and evaluative information are used. Procedural responsibilities performed by Center professional and clerical staff are specified.

ACTIVATING THE DELIVERY SYSTEM:

A contact person (usually a counselor) has been designated at each participating school to serve as a liaison between the school and Center. In addition to the counselor, each school has the services of other specialists on either a full or part-time basis. These resource personnel comprise a diagnostic, prescriptive and remedial services team which functions in the school setting, and they are referred to as a DPR school team. When a classroom teacher becomes concerned about a child with learning and/or behavior problems, she usually discusses the child with the counselor who brings the case to the attention of the DPR school team. It is the DPR school team that decides which children will be referred to the Child Study Center.

The school contact person assumes the responsibility for completing a referral form for children identified by the school team to be in need of the comprehensive services of the Center. Written parent permission is obtained as part of the referral process. Parent permission has an implicit meaning for Center personnel, that is: 1) school personnel have conferred with the identified child's parents about the child's problem, 2) Child Study Center services have been, at least briefly, described to the child and parents and 3) parents desire Child Study Center services.

The referral form is sent to the central Pupil Services office. A copy of the form is forwarded to the Child Study Center with previous service information indicated. Although information may be obtained about a child via a pre-referral meeting or telephone call, data collection formally begins upon receipt of the referral form at the Center.

The CSC secretary receives all new referrals, requests reports of previous services provided the child, makes up a file card and places the referral form in a folder titled "New Referrals". The contents of this folder are reviewed each week at staff meetings. A staff member is responsible for intake co-ordination which includes reviewing reports of previous services and presenting this information at a Center team staffing.

When possible, a parent intake interview, school observations, and conferences with school personnel are completed prior to formal evaluation. The intake interview is usually conducted by the Center social worker. Subsequent classroom observations and scheduling of conferences at school are assumed by the case coordinator. Behavioral observations in several settings at school are desirable.

Studying the school cumulative folder provides the Center a longitudinal perspective of a child's academic, medical and social problems. A record of previous services not listed on the referral form or conflicting information may be discovered when examining the cumulative folder. The student's original enrollment form often contains a record of parent comments, previous schools attended and the source of the birthdate. Brief conferences are frequently held with the child's current or previous teachers to discuss observations and/or data in the school folder. These conferences frequently expand upon or clarify the referral reason.

The following list is a guide to making a useful pre-evaluation visit to the school:

A. Review of records
   (1) Excessive absences and reasons.
   (2) Academic strengths and weaknesses.
   (3) Group test results.
   (4) Outstanding parent/teacher comments.
   (5) Indication of first sign of "problem".
   (6) Referrals or services not noted on referral form to Center.
   (7) Any previous recommendations and follow-up implementation.
   (8) Unusual growth/health patterns.
   (9) Confirmation of data such as date of birth, schools attended.

B. Observations
   (1) Peer interaction in various settings: age level, physical size, sex, in group, parallel or individual play.
   (2) Adult interaction: principal, teacher, professional observer.
   (3) Classroom participation and activity level.
   (4) Physical appearance, hygiene, expression, nails, clothing, mannerisms.

CENTER STAFFINGS:

Staffings are held formally each week. Previous to actual staffings, staff members note on an agenda clipboard any item or case need they wish considered by the team. One staff member takes minutes of salient planning decided upon during staff meetings. On an informal basis, there is frequent interchange of findings among staff members.

The contents of the "New Referrals" folder are routinely reviewed during staffings. After this review, the child is placed on an Active Caseload list. This list is updated each month and copies are provided each staff member. The list also itemizes each closed case during the current school year. Information on the list includes the child's name, school, grade, case coordinator and the date each case was opened. The Center secretary prepares a file folder for each child which contains copies of the referral form, parent permission form, previous reports and correspondence. As services are provided, service record reports, individual evaluation reports and a composite report are added to the folder. The service record contains entries by each staff member of any contact with or for the child; e.g., contacts with parents, school personnel, doctors, and other community personnel.

A Center staff member is assigned as the coordinator for a given case and becomes responsible for following up requests for previous service information including medical and community agency reports. The case coordinator communicates with school personnel as needed, brings the case to the attention of Center staff for study of individual findings, and assumes editing responsibilities for developing a composite report. When appropriate, the case coordinator is changed as the individual case study develops.

SCHEDULING OF CHILD:

Scheduling decisions are based on several variables, including transportation of the child, the date the child's case was opened, the location of the school, and the amount of testing a child may need. A form letter from the case coordinator is sent to parents and the school contact person to inform them of the time of the initial evaluation sessions.

Following the full evaluation of the child at the Center, the case coordinator communicates with the school contact person to arrange a conference among the child's teachers, other specialists working with the child and the Child Study Center staff. The Center social worker schedules a follow-up parent conference attended by Center staff. Both these conferences are held for the purpose of sharing evaluation findings in detail and recommending follow-up steps.

Following the full evaluation of the child at the Center, the case coordinator communicates with the school contact person to arrange a conference among the child's teachers, other specialists working with the child and the Child Study Center staff. The Center social worker schedules a follow-up parent conference attended by Center staff. Both these conferences are held for the purpose of sharing evaluation findings in detail and recommending follow-up steps.

When a school conference is held prior to a parent conference, a summary is shared with the parents. Also, when the parent conference precedes the school conferences, an overview is shared with school personnel.

See APPENDIX E for Child Study Center forms.

EVALUATION METHODOLOGY

Orientation

Evaluation is the central process employed in the study of the child referred to CSC. Evaluation at CSC is a fluid, flexible, ongoing set of activities. The purpose of these activities is to identify factors operating in both the internal and external environments of the child which influence the child's learning success.

Although evaluation is not a static part of rigid scheduling, it generally occurs following initial intake procedures and collection of background data. This scheduling allows team members to familiarize themselves with the needs of the case as stated in the referral, and with previous activity in the school and community which may be influencing the present status of the child in the learning situation. The Center specialists recognize the need for objectivity and a certain naivete' when beginning any evaluation. However, we feel that some comprehension of the Gestalt of the manner in which the child interacts with persons at home, at school and in the community, will provide insights about the nature of the educational problem and suggest probable areas of evaluative emphasis.

Generally, initial assessment activity is scheduled for a period of three consecutive days using three to four hours of child-contact time per day. The CSC staff finds that scheduling four or five children for assessment during this same time period each week allows for maximum use of both child and examiner's time, while keeping fatigue levels at a minimum. This kind of scheduling requires arrangement of reliable transportation for children to and from the Center. This arrangement is dictated by resources available either directly from the Center or through parents, school or community services. It is important that these arrangements be agreed upon well in advance of scheduled assessment dates and confirmed just prior to evaluation dates.

Process

The Child Study Center evaluative process combines three distinct types of activity. One type of activity is that which occurs during assessment by the individual specialists who comprise the team. It employs both formal and creative testing procedures directed toward analysis of the child's strengths, weaknesses and current level of functioning in specific areas related to learning. Another activity occurs at the team level, and consists generally of intra-staff consultation for the purpose of synthesizing test data into a comprehensive picture of the child's present status and educational needs, with a resultant prescription for remediation. A third type of activity refers itself to supplementary evaluation and consultation by sources outside the immediate CSC staff, with integration of this kind of information into the evolving composite report.

The first activity which usually occurs in the Center evaluation is the individual analysis of the child's potential and functioning in his environment by team social worker, psychologist, educational diagnostician and speech pathologist. Each specialist sees the child (parent, in the case of the social worker) for a period of time which may vary from one to four hours or more. Ideally, the case coordinator has made a classroom observation of the

child and studied the school folder prior to the scheduled evaluations at the Center. Behavioral observation is an integral part of all assessment activities at CSC.

During the time the child attends the Center, he is seen by each practitioner. All testing within each discipline may be accomplished in one continuous time period, or the child may work with an examiner for several short periods moving back and forth between areas. This procedure is determined by the ability of the child to remain on task without fatigue, his need for both mental and physical movement, and the examiner's need for specific information on test results from colleagues.

It is assumed that each potential member of a diagnostic team has developed, through training and experience, a methodology and philosophy concerning the practice of his profession. What follows, therefore, is not a set of rules for each discipline's procedures, but rather is a general orientation which has evolved from participation in the interdisciplinary process by Child Study Center staff. Generalizations regarding the evaluative responsibilities of individual team members follow.

The Center social worker arranges an initial evaluative conference with the parents who assist in further defining the nature of the child's problems by providing information as to the child's development, the family history and current family dynamics. These procedures normally precede the evaluation of the child at the Center.

The psychological assessment includes testing and observation to determine intellectual functioning and potential, personality adjustment, social-emotional development, and possible neurological dysfunctioning.

In the evaluative process of the Center, the educational diagnostician is responsible for assessing the learning aptitude and academic functioning of the student. Specific areas of examination are: the functioning of the learning modalities; the preferred learning style; vision acuity and visual perceptual development; visual-motor integration; reading, spelling, writing, language development, math and study skills. Data from test results and observations are used in determining the present grade level functioning in each area, but more importantly, in analyzing the specific learning and academic needs of the student so that an efficacious instructional program can be devised.

The communication evaluation encompasses the areas of speech, language and hearing. Specific skills which are examined include: articulation, fluency, vocal production, oral mechanism, vocabulary, syntax, grammar, auditory acuity, and auditory perception. The general purpose of this phase of the diagnostic process is to determine whether a communication dysfunction exists, and to what extent it interferes with the child's ability to learn.

In Appendix B there is a list of specific test instruments which may be used during the evaluative sessions. This list, while not complete, attempts to be comprehensive. It should be noted that, while this list is divided into discipline headings, many of these instruments may be employed interchangeably by team members, as need and time indicates. Rationale and use of these tests are well-defined in their respective manuals. Administration of any test is determined by the revealed needs of each case, so that not every test is given to each child. Staff members attempt to familiarize themselves with current measurement instruments as they become available so that they may determine those which might best tap any specified skill area.

In addition to standardized testing, CSC staff may devise and use unstandardized procedures in order to explore a child's functional levels. One such technique being used at the Center currently is video tape-recording. A one-half to one-hour video tape of the child engaged in spontaneous verbal activities with an adult examiner is often obtained. From such a tape, many diagnostic cues may be obtained. For example, a speech/language sample can be made, detailed observation and charting of non-verbal behaviors is possible, or an in-depth analysis of verbal interaction can be done. The tape may have value not only for immediate team use, but also when relating to others such as a pediatrician, teacher, parent, or even the child himself.

Another technique often employed during the diagnostic process is analytic teaching. That is, once an area for investigation has been identified, the examiner may elect to design learning situations which involve that particular area, then analyze, through actual practice, possible teaching and learning styles to discover those that work most efficiently for an individual child. This may require several hours, days or weeks of time, but often yields highly-effective methods for use by classroom teachers.

Concurrent to and following individual evaluations, team conferences to synthesize test findings are held. These conferences may be informal, involving one or two team members, or may occur at formal staffings scheduled following completion of initial assessment procedures.

Informal team conferences often involve feedback concerning findings or occurances during testing which relate to another team member's discipline. This information is relayed by the observing examiner to the team member responsible for conducting an in-depth exploration of the area in question.

The staffing which is scheduled following completion of testing at the Center, serves to both synthesize and describe the results of the evaluations. Multiple data are carefully studied. These data may include inconsistent findings among practitioners and between current findings and background data. Team members discuss these case findings and their concomitant implications. This analysis is a search for a pattern or matrix on which the pieces of the puzzle can be formed.

Some of the questions for which answers are sought include the following:

1. Which revealed deficit appears to be most basic to the child's lack of success?
2. Are there factors existing outside the learning areas which are blocking progress?
3. What strengths are available for use in remedial intervention?

Formulating answers to these questions demands close teamwork with continuous focus upon the child rather than professional status. Each team member has the responsiblity of maintaining this focus.

In some cases, a need for consultation and/or evaluation by a discipline outside the CSC staff is required. The need for contact with professions such as pediatrics, dentistry, psychiatry or visual specialists is discussed and agreed upon during team conferences. This need is then discussed with parents before referral is made. When an appointment is obtained, CSC will make available to the consulting professional pertinent information regarding Center findings and questionable areas for which additional data are needed. Whenever possible, a conference as well as a written report is requested by CSC following this contact. Any forthcoming information and recommendations by the consultant are then integrated into the comprehensive educational

planning by the Child Study Center and the school.

Product

Each team member is responsible for composition of a report of specific results, diagnosis and suggestions for every evaluation performed. Copies of written report forms used at the Child Study Center are found in Appendix E. Subject to minor variations, this report contains:

1. Specific results of evaluation procedures, usually defined by skill area. Test scores are not always included, although function and grade levels are stated.
2. A summary and diagnosis based on findings related to that particular discipline.
3. Recommendations related to avenues of remediation. These may include referral to special school services, change in mode or level of classroom instruction, suggestions related to home activities, requests for consultative services such as medical examination.
4. As needed, prescriptive programs designed to incorporate the recommendations. For example, activities which may be used in the classroom, tutorial programs, contracts, or behavior modification schedules may be provided to facilitate remedial plans.

These reports are filed in the Center file. Upon request, copies may be given to a classroom teacher or school specialist to be used as reference points in remediation. Another copy, or abstract thereof, is given to the case coordinator.

The major, written product of Center activity is the Composite Report. The coordinator assigned to each case is responsible for integrating all available written information, results of conferences and recommendations into a comprehensive picture of the child's present functioning as related to his potential, and a consensus plan for remediation of any dysfunction indicated. With some exceptions, this report is finalized following parent and school conferences. This timing is followed to increase the probability that recommendations and programs contained in the Composite Report will clearly reflect the thinking and responses of all those involved in the future educational planning of each child. Two copies of this report are sent to the child's school; one to be kept by the principal, another to be available for teacher use. A copy of the Composite Report form used at the Child Study Center is found in Appendix E. In addition to the evaluative process described, the Child Study Center staff is continually available for further evaluation or post-testing as need or request dictates.

CONSULTATION

CONCEPTUAL APPROACHES:

The consultation strategies implemented by the Child Study Center staff represent an integration of the consultation knowledge and skills developed by individual specialists prior to joining the Child Study Center program. Team members came to the Center with an approach to consultation unique to each discipline represented in the team. As the process of group interaction gradually integrated individual specialists into interdependent team members, a plan for coordinated consultation activities evolved.

Although the Center staff did not attempt a formal study of consultation theory and practice, a brief literature review was conducted. Consultation as described in community mental health literature has been relevant and transferrable to the Center experience. However, the main functions of the Center program are to conduct comprehensive diagnostic studies, develop remedial plans and share these findings extensively with consultees. Consequently, while Center personnel use consultation strategies, the delivery system of the Child Study Center is more comprehensive than a traditional mental health consultation approach.

The consultation processes delineated in this report are implemented by Center personnel consistent with the purposes of the Center.

1. Consultation may be defined as an interaction among professional peers which has the potential for mutually influencing participants in a positive direction. Consultation is oriented toward a problematic issue, the formulation of a task or the completion of a formulated task.

2. The client (child) whose problems are the center of the consultation process is the person (child) for whom the consultee (teacher and parents) are responsible. Before consultation in a school system can be effective, it is important that the consultant learn about the school's organizational structure and climate. He should familiarize himself with methods used by the school to deal with problems prior to the availability of the new support service. For consultation to be effective, sanction at all levels of the hierarchy within the school system needs to be secured and periodically reviewed.

3. Being geographically external to a local school building provides an opportunity to assume a degree of flexibility and latitude not always possible when consultation is carried on exclusively by school based personnel. Also, collaborative effort between Center staff and school staff offers an efficacious approach for enabling the referred children to experience improved functioning, academically, intellectually, emotionally, socially and physically.

4. The process of consultation depends upon the communication of knowledge, skills and attitudes operant in the interaction and can, secondarily, have a broader educational effect since the teacher may learn to more successfully assist children with needs similar to the needs of a referred child.

5. Consultation is often a temporary process provided on a short-term basis and therefore limited in scope and usually concerned with a specific problem. (It is the consensus of the Center team that more than the minimum of two follow-up consultations with school staff and parents are needed to provide sufficient supportive help for implementation of recommendations. This aspect of Center service requires continual evaluation.)

6. Consultation is not supervision even though the educator may be better able to do her job as a result of the consultation process. Consultation is the interaction among key persons interested in more effective utilization of their professional roles with regard to a particular child and does aid in a better appraisal of a particular child's needs.

7. The consultant usually plays an advisory role, and does not implement a plan to solve the problem himself; that is, the consultee (educator or parent) is expected to carry out the steps of problem solution in the actual classroom or home situation.

8. Finally, consultation is non-administrative in nature and does not authoritatively demand participation or committment to a selected solution strategy. Rather, the success of consultation is dependent upon establishing mutual respect and shared control among participants.

STAFF COMPETENCIES:

The following staff competencies are recommended to enhance the success of consultation intervention.

1. The consultant must possess a solid knowledge of, respect for and identification with his specific professional role.

2. The consultant should have an understanding of the diversity and comprehensiveness of consultation strategies when implemented in a team approach delivery system.

3. The consultant must demonstrate respect for the consultees and perceive them as capable of facilitating positive development in their clients (referred children).

4. The consultant must be able to assume a colleague relationship rather than a professional-patient relationship with the consultee. This is also true when consulting with the child's parents.

5. The consultant must be aware of his own feelings and reactions while maintaining a focus upon evolving a plan which meets the needs of the referred child.

MODES OF CONSULTATION:

Consultation, then, has been described as a sharing, interactive, task-oriented, short-term, diversified, collaborative, educational, non-authoritative and informative communication strategy. It is an on-going, fluid process which is responsive to the needs of the participants and the concern which they have for their clients (children). Also, it should be noted that in most consultative situations more than one Center team member participates with the school staff, parents or other involved persons in the community. While the knowledge of individual Center specialists is shared, the Center team must function as a unified whole to promote collaborative involvement.

The more common modes of consultation as experienced by Center staff are informative, interpretive and facilitative. A key dynamic for effective consultation in each mode is clearly defining the issue or problem under consideration.

Informative:

Informative consultation frequently occurs among Center staff at regular weekly team meetings. Exchanging individual specialist's knowledge, describing evaluation findings, sharing opinions regarding key problematic areas and discussing priorities for remedial/preventative aspects of the child's problem are areas explored during this consultation mode. The productiveness of informative consultation strategies is in direct ratio to the diagnostic and prescriptive competencies of the team members.

Informative consultation is emphasized during follow-up conferences with parents conducted to share findings and recommendations. During these conferences, it is important for the team to be aware of the anxiety which the parents may be experiencing. Also, it is essential to allow sufficient flexibility and time for the parents to comfortably interact. Imparting information about the identified strengths of the child early in the consultation period, and encouraging parents to discuss these positive findings, helps establish a constructive climate for consulting effectively.

Although participating parents are not usually professionals in education or a related specialty, they have knowledge about their children which places them in a genuine position of colleagueship. If this factor is overlooked, informative consultation may deteriorate into a quasi-lecture leaving the parent with burdensome knowledge about the child's performance and potential.

In addition, informative consultation occurs when Center staff confers with a medical doctor or other specialists. During staffing sessions with the Center Pediatric Consultant, the roles of consultant and consultee become obscure and all participants share both roles in a dynamic process.

In our community there is a vital awareness among medical practitioners of the need for collaborative consultation for children with multiple learning problems. The Center staff has a medical consultant who attends staff consultation conferences once a month to discuss children referred for medical evaluations. Medical services and consultations are also provided by the State of Florida Children's Medical Services Division and the Child and Family Comprehensive Mental Health Center at the local All Children's Hospital.

Interpretive:

Interpretive consultation occurs to some degree during Center staff and parent conferences, but is primarily experienced during conferences with school personnel. At the beginning of a Center-school staff conference, information from Center findings is shared on various aspects of the child's functioning as assessed by each Center specialist. School staff share coinciding or differing information and provide current observational data. The shared information becomes the basis for interpretive discussions exploring the child's learning behaviors, social skills, personality development and physical condition. After an assessment the child's needs are defined and clarified, a consensus may be reached in the selection of solution strategies for meeting the child's needs. Sometimes participants may express a desire to obtain additional data before attempting a solution.

An effort is made to include participation from relevant resource personnel within the school in implementing solution strategies. Remedial plans may be implemented by a speech therapist, learning disabilities specialist, itinerant psychologist, reading/language arts specialist, itinerant social worker, qualified tutor or instructional paraprofessional. If the consultation results in adjunctive assistance from out-of-school resources, specific school personnel will assume responsibility for appropriate follow-up. Essential to this kind of consultation is a mutual respect by all participants for the expertise of each and a mutual acceptance for differences. Although the Center assumes evaluative and consultative accountability for compensatory and corrective recommendations, the Center program must respect and support the direct responsiblity of the school staff for the learning and behavioral development of the child.

Facilitative:

Facilitative consultation may be experienced between Center team and school staff or between Center team and parents, but most often occurs prior to referral to the Center or the initiation of Center services. For example, Center personnel and the contact person in the school consult when resistance to Center services is expressed by a child or his parents. Facilitative consultation frequently occurs when considering special approaches to delivering services which might enhance communications with school personnel, parents, or a child whom the teacher feels is in crisis and requires priority consideration. Another need for facilitative consultation occurs when further interpretation or consultations with school personnel, medical practitioners or parents are necessary to develop valid recommendations and facilitate their implementation.

Facilitative consultation is provided for overcoming special problems and thus may necessitate a departure from normal procedures. However, it is important for Center personnel to maintain a focus upon the objectives and implementation strategies of the CSC program while attempting to accomodate crisis needs of the child and the system of which he is an integral part.

In summary, the Child Study Center program has concluded that consultation is a key vehicle without which the comprehensive study of a child's strengths, problems and potentialities might simply become unread pages in an unopened folder.

REMEDIATION STRATEGIES

The remedial efforts of the Child Study Center are designed to assist each child to improve learning, communication, and academic skills as well as to increase the frequency of productive social behavior.

The remedial plans are expressed in writing within a "Composite Report". This report, which synthesizes the observations and findings of individual specialists, contains recommendations and individually prescribed instructional/behavioral programs.

Implementation of the Center's recommendations and specific prescriptions usually involves many persons. The following resource persons are routinely involved in every case.

1. Parents or guardians - The degree of involvement in the actual remediation process varies greatly according to the needs of the child and the parents' desire and ability to participate. However, all parents are given the opportunity to receive and share information related to the child's evaluation and progress.

2. School-based personnel - The student's classroom teachers and various members of the school team are actively involved in implementing recommended strategies. School personnel, other than classroom teachers, who may share in the remedial process are: counselors, deans, principals, psychologists, social workers, speech clinicians, learning disabilities teachers, and reading-language arts specialists.

Other resource personnel frequently requested to participate in diagnostic and remedial processes include:

1. Medical personnel - such as pediatricians, psychiatrists, ophthalmologists, and dentists.

2. Personnel from local resource agencies - such as child and family counseling services, social-welfare programs, vocational training and rehabilitative programs, or speech and hearing clinic services.

3. Personnel from residential treatment/care centers which provide for severe emotional, social, and psychiatric cases.

4. Special school resource personnel - from programs such as adult education, exceptional student services, work-experience, and comprehensive junior or senior high schools.

Center personnel limit their participation in direct remediation processes to short-term interventions. The Center's major remediation strategy is to facilitate implementation of remedial plans by consulting with parents, school personnel and involved community professionals. The consultations are designed to accomplish the following objectives:

1. To stimulate and activate joint efforts among school, home and community resources.

2. To aid parents as well as to enlist and maintain their support and involvement.

3. To report and interpret the diagnostic findings of each study.

4. To offer remedial suggestions and to establish a methodology for effecting the desired remediation.

5. To modify factors in the environment which affect the learning process and to monitor effectiveness of remedial strategies.

6. To aid in the implementation of the prescriptive educational program by demonstrating applicable methods and materials, by providing recommended materials, and by contacting, training, and supervising tutors.

The primary goal of CSC in the remediation process is to maintain open lines of communication and active cooperation among all resources involved in providing services designed to lead to successful experiences for each referred child.

To illustrate more specifically CSC's role in the remediation process, two case studies have been summarized which present diagnostic findings, recommendations, specific instructional suggestions, and a report of follow-up activities.

SAMPLE CASE SUMMARIES AND REMEDIAL PLANS

CASE I

Bobby, a thirteen year old sixth grade student, was referred to CSC by his school team in order to obtain recommendations and information to assist them in instructional and correctional planning. Bobby had been having learning problems throughout elementary school and had spent three years in first grade. Now, school personnel were not only concerned about his academic achievement, but about his personal and social development.

Summary of Center Findings

Bobby's current intellectual functioning is in the dull-normal range, with the Verbal IQ being considerably lower than the Performance IQ. Bob's responses on psychological measures suggest feelings of inadequacy and latent hostility.

His speech is characterized by numerous omissions and distortions of speech sounds, possibly due to a soft palate which may be inadequate for the depth of the pharyngeal cavity. Receptive/expressive language skills are approximately four years below his chronological age. Deficits exist in short-term auditory recall, syntax and grammar skills, and in word finding. Auditory acuity is normal but there is a severe dysfunction in auditory discrimination ability.

Tests used to assess the functioning of the learning modalities indicate that weaknesses are present in both the auditory and visual channels, as well as in verbal expression and reasoning ability. Bob showed improved performance when visual and auditory stimuli were used simultaneously.

Bob's reading-spelling instructional level is mid-first to beginning second grade level. His word attack skills are non-existent. While he was able to reproduce a few consonant sounds in isolation, he rarely uses this knowledge in encoding or decoding tasks. Both his reading and spelling performances are entirely dependent upon his known sight vocabulary.

Math functioning level is comparable to mid-third grade standards. He is able to compute three-digit column addition problems with regrouping, and simple multiplication and subtraction algorithms. He has difficulty with zero and regrouping in subtraction and with most of the multiplication facts. He seems totally unfamiliar with division, fractional numbers and abbreviations such as hr. and yd.

Bob is a severely disabled student with physical, speech and learning problems compounded by socio-cultural factors. Because of these limitations and resultant reading difficulty, Bob is functioning like an EMR child.

Recommendations

1. Explore a special class placement for Bob such as an EMR room in a regular school.

2. Obtain a medical examination for exploration of possible interference due to physical/neurological factors.

3. Schedule an evaluation by the Cleft Palate Team, All Children's Hospital, regarding possible velopharyngeal insufficiency.

4. Contact the Vocational Rehabilitation Service to determine services available to Bobby through this program.

5. Provide intensive language stimulation with emphasis on skills of short-term recall, sequencing, categorization and auditory perception.

6. Reading instruction should be given primarily on a one-to-one basis. Some small group work can be used when appropriate for a specific task.

7. Reading instruction should emphasize:

   a. the continued development of a sight vocabulary.
   b. the use of structural and contextual cues for use in independent word analysis.

8. A multi-sensory approach for both reading and classroom presentations is indicated.

Suggested Instructional Program

Reading Instruction:

1. Build a sight vocabulary.

   a. Use the VAKT approach as needed. (See attached sheet which describes this method of word-learning.)

   b. Use words from the accompanying sheets as a source of useful words.

      (1) Durr's List of High Frequency Words
      (2) Important Words

   c. Use words of special interest to Bobby.

   d. Let Bobby keep a file of his words.

2. Use the language-experience approach to reading, at least part of the time.

   a. Incorporate words being built into the sight vocabulary when possible.

   b. Add new words from his stories to his sight vocabulary.

3. Teach structural clues and word patterns.

   a. Add prefixes and suffixes to known words.

   b. Teach the common word patterns (as presented in Merrill).

   c. Use of the reading series by SRA, Cracking the Code can be initiated after a more satisfactory sight vocabulary has been established and some of the basic pattern words have been learned.

4. Supplementary Activities and Materials.

   a. Have Bob use a listening center for read-along stories to reinforce vocabulary, for motivation, and to further integrate the auditory-visual channels.

      (1) Bomar Kits should have appeal for him.

      (2) Scholastic's Reader's Choice has many titles available for a modest cost.

      (3) Essential content from textbooks and other books available in the room can be recorded on cassettes. Although Bob is unable to read independently, he could participate in classroom discussions and activities if given an opportunity to learn the content material by listening to the cassettes.

   b. Have Bob study Using the Context A & B, (Barnell-Loft).

   c. Supplementary readers which can be used to reinforce known sight and pattern words are:

      (1) Stanchfield's Appreciate Your Country series.
      (2) The Merrill Linguistic Readers.
      (3) The Sullivan Readers.
      (4) SRA Basic Reading Series.
      (5) Miami Linguistic Readers.

Follow-Up

1. A joint Center team - school team conference was held to share Center findings and recommendations, as well as current school functioning and behaviors.

2. A parent conference was held at the Center following several phone contacts. Findings and plans were discussed and views exchanged.

3. CSC provided a pediatric-neurological examination through the consulting pediatrician, which revealed delayed neurological maturation. Stimulant medication was prescribed on a trial basis.

4. Bob was also seen by the Cleft Palate Team, All Children's Hospital, under CSC auspices. They found no physical anomaly requiring surgical correction, and recommended (1) an audiological evaluation; (2) continued speech therapy; (3) an orthodontic consultation.

5. CSC team aided parents in obtaining a special placement for Bob in the county's Exceptional Student Education Program. (He is now enrolled in the EMR program in a junior high school close to his home.)

6. Placement with Vocational Rehabilitation Services was also achieved.

7. Copies of Center findings, recommendations and instructional suggestions were sent to all persons who had been involved in providing assistance.

8. Suggested academic and speech/language programs are currently being implemented by school-based personnel.

CASE II

Introduction

Lloyd, a twelve year old boy, was referred to CSC because of learning and social/emotional problems.

Summary of Center Findings

Lloyd possesses at least average intellectual ability. Lloyd's responses to social-emotional measures indicate that he tends to demonstrate little affect, and that he protects himself from emotional pain or rejection by not extending himself out into the environment; i.e., by not trying to grow or learn.

Lloyd's developmental and medical history are not indicative of growth or health problems. However, it was recently discovered that he has stomach ulcers. He is responding well to medication and a strict diet. Lloyd's relationship with his father, as described by his mother, is tenuous. Since the parent's divorce, and subsequent remarriage, the father-son relationship has been strained, according to Mrs. Smith. Also, she views Mr. Smith as too demanding and impatient with Lloyd. Mr. Smith is described as being a strict disciplinarian, industrious and a good provider. Mrs. Smith seems to accept Mr. Smith's forceful personality, but resents his domination of the children. Consequently, there seems to be an alignment of mother and children in opposition to the father. During the Center parent conference, Mr. Smith seemed very sincere in his self-appraisal and specifically requested tutorial help for his son.

Lloyd exhibits generally adequate communication skills. There are indications of a specific deficit in auditory recall ability. Emotional problems may be a factor in this deficit.

Testing revealed that Lloyd has severe deficits in auditory and visual recall and in all academic areas. Single consonant sounds appear to be the only phonics skill that Lloyd has acquired. Unfortunately, he does not consistently apply this phonics skill in reading and spelling. His oral reading is very inaccurate, but his silent reading performance indicates that he does make use of some contextual and pictorial clues.

Recommendations

1. Lloyd should benefit from individual tutoring focusing on his specific needs and adapted to his instructional level.

2. Lloyd may benefit from a more appropriate school placement for the 1974/75 school year. Clearwater Comprehensive Junior High School is recommended as a possibility to be explored by Lloyd and his parents.

3. Family counseling is recommended to facilitate effective communication and positive interaction.

4. Individual counseling sessions for Lloyd are also recommended to help him become more aware of his feelings and ways in which he can learn to express them.

Suggestions for Instruction

1. Visual Motor Skills

Lloyd needs further training in motor skills as he had low scores on all motor tests. Activities to help improve eye-hand coordination are:

a. Chalkboard activities (suggestions attached).
b. Visual Motor activities Sets I and II.

2. Auditory Attention and Memory

Learning is dependent to a great extent upon listening for directions, understanding and comprehending instructions and remembering what has been said. Lloyd has severe deficits in this area and any instruction should include sequential activities to strengthen this channel.

a. Repetition in sequence -

Call out numbers or letters of the alphabet in a series and have the student repeat them verbatim. Lloyd should begin with three or four in a series and increase the length of the series as he becomes more proficient. Variation could include double and triple digit and letter groupings. Example:

Single digits and letters
3 - 2 - 3 - 7 - 3 - 4
a - g - f - h - p - r

Double digits and letters
42 - 28 - 24
ad - fg - hj, etc.

b. Repeat words, phrases or sentences. Gradually increase span.

c. Provide practice in understanding and following verbal directions. Gradually increase the number of directions as proficiency increases.

d. To help Lloyd attend to and understand stories, paragraphs and sentences, have him listen to a short story and then repeat events in the story or answer questions about it.

e. Classifying: Read words and have Lloyd pick out the one that does not belong in the series.
Example: newspaper, magazine, book, broom

f. Categorizing: Put words in proper category and repeat all words.
Example: Germany, France, Italy are all _____ (countries).
Beets, carrots, peas are all _____ (vegetables).

3. Visual Discrimination

It is necessary to correct problems of incorrect identification of letters in a line of print, the incorrect sequence of letters within words, rotations and reversals of letters and to establish left to right directionality in reading printed materials. The Teaching Series from Ann Arbor Publishers is recommended:

a. Visual Tracking
b. Word Tracking

4. Visual Memory and Attention

   a. Display a figure, picture or other reasonable facsimile for a limited amount of time (5 to 15 seconds) and have student either reproduce it or describe it. Always give him the opportunity to compare his results with the original.

   b. Display a series of letters, numbers, pictures and have student tell them in same order.

   c. Use Symbol Tracking of the Michigan Tracking Series - Have student study stimulus figures at top of page, cover them, then mark them off in their correct order.

   d. Present an incomplete figure, withdraw it, and have student tell what was missing.

5. Academic Instruction

   a. As testing reveals, Lloyd has average potential for achievement, but his effort to work to his optimum is hindered by his feelings of inadequacy and failure to meet adult expectations. It is therefore mandatory that instruction should be at a level where success is insured from the first lesson.

   b. Cracking the Code, Science Research Associates, is recommended for instruction.

      This series is for students in the fourth to sixth grades who have not become independent readers. This seems to be especially appropriate for Lloyd as his difficulty doesn't seem to be getting meaning and comprehension from reading, but one of decoding the printed word into familiar language.

   c. Some materials that may be correlated with Cracking the Code are:

      (1) Merrill Linguistic Readers
      (2) Sullivan Associates Storybook 1 through 6
      (3) Stanchfield's Appreciate Your Country Series

The staff of the Child Study Center is available for further consultations regarding Lloyd's program.

Follow-Up

1. A school-Center conference was held in order to relate findings and recommendations.

2. A parent conference was held at the Center. The recommendations listed above were discussed with Mr. and Mrs. Smith. The parents (Mr. Smith in particular) were reluctant to participate in family counseling. They indicated a desire for tutorial help for Lloyd and that they would consider applying to Clearwater Comprehensive Junior High School.

3. Lloyd participated in remedial sessions with the Center educational diagnostician twice a week for two months. Lloyd made excellent Progress in reading skills and exhibited a marked attitudinal change. He showed an interest in independent pleasure reading for the first time. At Mrs. Smith's request, the educational diagnostician helped select books which were then purchased for Lloyd to read during the summer.

4. Lloyd was placed in the recommended comprehensive junior high school at the beginning of the school year. Center reports were sent to the school and conferences held with school personnel, Lloyd and Mrs. Smith in order to facilitate adjustment to the new school situation.

ROLES AND FUNCTION OF PRACTITIONERS

ROLE OF THE EDUCATIONAL DIAGNOSTICIAN ON THE CENTER TEAM

The educational diagnostician has two basic responsibilities to fulfill as a member of a comprehensive diagnostic team, in addition to the routine duties shared by all team members. Conducting an in-depth evaluation of learning aptitudes and academic achievement is the first major responsibility. The second is facilitating the remediation of learning problems experienced by referred children.

EVALUATION:

The educational diagnostician is responsible for assessing the learning aptitude and academic functioning of each referred student. This is accomplished through the administration of a battery of tests which includes both standardized and informal instruments, and through observations of the student's behaviors related to the approach and execution of the evaluation activities.

Evaluating learning aptitude refers to measuring the efficiency with which the student is able to use the sensory pathways for receiving, processing, retaining and retrieving information. Physical factors, verbal abilities, general comprehension, reasoning ability and learning modalities are studied for each child in evaluating learning aptitude. Physical factors, which may have an adverse effect upon learning are studied during the evaluation process. These factors include: visual acuity, lateral dominance, gross and fine motor development, general body awareness including right-left discrimination, time and space relationships and directionality.

Normal physical development and health contribute to adequate functioning in the school environment. Physical well-being and efficiency are important not only for academic success but for the development of a positive self-concept. Therefore, an assessment of selected physiological factors is an essential part of the total evaluation.

An evaluation of knowledge and understanding of vocabulary word concepts and relationships provide an estimate of a child's verbal ability. An essential ingredient in a child's ability to perform in a regular classroom setting is his skill in understanding the terminology commonly employed and in being able to translate what he hears into meaningful action. A child with deficit verbal ability is handicapped from the beginning of his school career.

General comprehension and reasoning ability is assessed by determining a child's experiential knowledge, social adjustment, and problem solving skills. The degree to which a student is aware of his surrounding environment, and his ability to interact positively with peers and adults has a profound effect upon future learning. A student's limitations in this area can be overcome by providing appropriate experiences based upon an assessment of his needs.

The learning modalities including visual, auditory, and kinesthetic tactile perceptual processes are evaluated extensively. An estimate of visual learning ability is developed by evaluating the following: attention and sequential memory, visual associative memory, discrimination, perception and visual-motor integration. Auditory learning ability is assessed by evaluating a child's performance in tasks which include: attention and sequential memory, following oral directives, listening comprehension and association.

The learning modalities are evaluated to determine the preferred learning style and the strengths and weaknesses within each modality. The learning modalities evaluation findings are used to provide compensatory experiences, through accommodating the child's best mode of learning, and to initiate remedial activities for strengthening deficit areas. The student's ability to integrate auditory and visual stimuli, and his need for reinforcement through the use of all modalities are noted as guides to planning compensatory instructional programs.

Another major part of the evaluation process performed by the educational diagnostician is an assessment of the current academic status of the student. The evaluation procedures vary according to age, grade level, and the expressed concerns of referring school personnel. Therefore, it may include some or all of the following areas: readiness skills, alphabet knowledge, phonic skills and structural analysis, reading, spelling, handwriting, math and study skills. Reading achievement is estimated by evaluating word recognition skills, oral and silent reading skills (both accuracy and comprehension), decoding skills and by analyzing reading errors. Math achievement is estimated by evaluating concept development, computational skills, application and problem solving skills.

Although results from academic tests are reported in terms of grade equivalent scores, the grade scores are not considered an important aspect of the learning report. Rather, they are reported to serve as an indication of the student's general academic functioning in relation to grade placement expectations, and to provide data to compare with previous or future test results.

The heart of the learning evaluation lies in the interpretation of testing behaviors and techniques employed by the student while performing academic tasks. Information gained from the evaluation process enables the diagnostician to determine the specific skills already acquired and utilized by the student, as well as identify skills needed in order to increase his learning efficiency. An analysis of errors and the style employed by the student in encoding and decoding tasks provides clues for prescribing teaching techniques and instructional materials appropriate to the student's needs.

A report of the test results and an interpretation of the findings are incorporated into a written report. Perusing school records for results of previous testing, consulting with school personnel and conferring with CSC staff members usually precedes the preparation of a formal report.

REMEDIATION:

The second basic responsibility of the educational diagnostician is to facilitate the implementation of remedial strategies. This is accomplished, primarily, by providing a prescriptive instructional program adapted to the

individual student's needs. This prescriptive program, which is a part of each learning report, contains recommendations and specific instructional suggestions which are both compensatory and corrective in nature. The remediation plan includes suggestions for teaching techniques and materials which appear suited to the student's learning style and academic strengths and deficits.

The educational diagnostician may assist in the implementation of the remedial program by:

1. Interpreting the learning report for involved school personnel.

2. Demonstrating recommended instructional approaches.

3. Demonstrating the use of suggested materials and providing materials unavailable in the school.

4. Training and supervising tutors and paraprofessionals working with the referred child.

5. Providing short-term diagnostic teaching sessions to determine the efficaciousness of the prescriptive program.

6. Following up with in-school personnel as to the child's progress.

7. Re-evaluating students and modifying prescriptions when appropriate.

The educational diagnostician shares in other duties common to all members of the team when assigned. These include:

1. Case coordination.

2. Review of school history and records of previous services provided the referred student.

3. Collection of current information through consultation with school personnel and classroom observation.

4. Routine record-keeping.

5. Participation in team staffings designed to coordinate efforts and set priorities for the treatment plan.

6. Composite report writing.

7. Participation in consultative sessions with parents, school personnel, and community professionals.

8. Providing in-service training for other educators.

THE PSYCHOLOGIST AND A CHILD STUDY CENTER TEAM

It is desirable for the psychologist on an educationally based, multi-discipline diagnostic team to have a broad educational and experiential background.

An individual psychological evaluation is the primary service provided by the Child Study Center psychologist. The results of individual diagnostic evalutions are shared with the Center team, school personnel, parents and others, in three comprehensive areas: intellectual, physical-neurological and socio-emotional.

Diagnostic procedures and instruments vary with case demands. In addition to the use of an individual intelligence test, gross and fine motor co-ordination measures and projective techniques; diagnostic activities include the use of observations, conferences and previous records.

Other responsibilities of the Center psychologist have included counseling students, individually and in groups, counseling parents and consulting with persons at various levels in the school and community. When appropriate, the psychologist assumes the role of coordinator for selected students. As case coordinator, the psychologist serves as an activator and facilitator to optimize the quantity and quality of services rendered.

The Center psychologist is a resource person to the team in the use and interpretation of: child growth and development knowledge; mental health factors; theories of behavior, learning and motivation; and principles of measurement, evaluation and statistics.

Rather than implementing a role as the solitary or primary diagnostician, the Center psychologist is one member of a diagnostic team. Thus, several diagnostic viewpoints are integrated to form a more comprehensive and intensive diagnosis. Although a team approach to diagnosis and consultation is followed, this in no way means a forfeiture of the primary professional and ethical responsibilities of the psychologist. The psychologist must actively participate in the interpretation of all findings upon which the team recommendations are made. The recommendations themselves and the effects which they are predicted to have upon the child and his school, family and community settings must be supported by all team members.

Particular care must be given to team consensus to facilitate a comprehensive and coordinated diagnostic, prescriptive and consultative service delivery system. Rather than viewing differences in diagnostic findings among specialists as sources of conflict to be debated, it is important to explore the interpretive meaning of these differences in developing an accurate diagnosis which can gain consensus among team members. The objective of the Child Study process is to enhance the learning and behavioral development of participating children. An effective team effort is required to accomplish this objective for each child.

The expenditure of energy and involvement in a team study approach may be higher than when a case is handled as an individual specialist. However, a well-maintained focus, with prescribed procedures and specific strategies, enables the energy and involvement of team members to be channeled into productive behavior. Although a team member may at times feel like a three-legged jackass harnessed backwards into a team of oxen, collaborative team work can be accomplished and effective services can be delivered.

PSYCHOLOGICAL EVALUATION

The psychological evaluation at the Child Study Center is part of an overall evaluation which includes an educational (learning) diagnosis, a communication evaluation and an analysis of social functioning. Supplemental medical, dental and visual examinations may become part of the evaluation procedure.

One primary purpose of the psychological evaluation is to describe the child's general intellectual level and to determine if the child has potential for greater academic achievement. Since referrals for determining eligibility for educably mentally retarded or emotionally disturbed classes are generally made to itinerant school psychologists, this is not a major function of the Center psychologist.

Diagnosis in areas such as minimal brain damage, social maladjustment and behavior deviation become a joint effort of the CSC team; however, data from the psychological evaluation is critical to the effort.

The Center psychologist attempted to develop a standard package of evaluation instruments, but found a need for flexibility because of referral reasons and other evaluations which the child may have recently experienced. The psychological evaluations for most referred children include administering an individual intelligence test, usually the Wechsler Intelligence Scale for Children (or WISC-R), and the Bender-Gestalt. Additional instruments and activities are selected in accordance with evolving hypotheses of the psychologist and other team members.

The Center psychologist prefers to use all of the Verbal Scale subtests (6) and five of the Performance Scale subtests of the Wechsler in the evaluation. The scores on WISC subtests are usually correlated with findings of other Center team members. Occasionally, diagnostic clues are revealed when WISC scores do not correlate with communication and learning evaluations. The psychologist studies the inter-relationship of each diagnostic clue, as well as score magnitudes and response patterns.

Also, observing the child's behavior during the examination period yields additional data which can enhance interpretations. The Center psychologist has found that he observes more effectively when sitting to the child's side or at a corner of a table rather than across from the child. When observing in this manner, the child is less likely to notice that his behavior is being closely monitored.

The Bender is used by the Center psychologist not only to obtain reproductions of the designs, but as an evaluative process (which needs to be observed). This latter area will be described briefly. The Center psychologist no longer scores the Bender reproductions, but uses the Memory-for-Designs if a formal score is wanted. A. Clawson's Manual is the basis for interpretations of the reproductions as well as recording the physical attack on the job by the child. It is suggested that a formal method of recording and scoring be used for several years until one is clinically sure of what can be of use in the shortest time.

When testing the child, the examiner observes the child's reactions to the oral directions as they are made. The examiner attempts to explore questions which may provide diagnostic information. Does the child look once, start, count, and re-count, or does he look, count, re-count and then finish without looking back? When "mistakes" are made and not corrected, what does his non-verbal expression mean? Did he see the mistake, grimace, and leave it alone? What does the re-counting mean in a given case? If there are slight irregularities in your card designs, does the child note these? Inquire at the end of the test for his observations.

When the child says something, what does it mean? Is he reinforcing himself, belittling himself, just talking or desire more direction? Does he count aloud? Does he tell you he goofed, but doesn't bother to correct it? What free associations does he make? How about motoric activity such as head bobbing, lips moving, actual touching of design, body/head rotating? What is the child doing with his feet? Does he work better standing?

The Center psychologist has found that omitting any of the designs is a false economy and he holds each card forcing the child to orient himself to the task.

More detailed suggestions for obtaining additional data while administering both the WISC and Bender-Gestalt are included in Appendix A: "Strategies for Enhancing Psychological Evaluations".

ROLE OF THE SCHOOL SOCIAL WORKER ON THE CHILD STUDY CENTER TEAM

The use of the social worker's professional capacities and specific contributions are in the areas of consultation, evaluation and coordination. More specifically, the social worker places an emphasis upon consulting with parents, evaluating the child's social development, and serving as a liaison person to help coordinate school, home and community resources.

Ideally, before the Center team has scheduled evaluation sessions for the referred child, the social worker arranges an intake appointment by telephone or letter with the parents, usually the child's mother. During this single interview, the social worker considers various aspects of the referral.

Although parents are aware that referral to the Center has been made, they rarely initiate contact. Frequently parents are unclear of the purpose of the intake interview and, thus, are somewhat apprehensive. For this reason, the social worker provides a complete interpretation of the full Center process and shares the school's description of the child's problem.

During this interview, the social worker establishes rapport with the parents in anticipation of follow-up communications such as the parent/Center team conference which follows the child's evaluation. Usually, the social worker will schedule this parent/Center team conference during the intake interview. A specific invitation is made for both mother and father to attend the conference.

The social worker obtains relevant information to aid in the team's assessment of the child's level of emotional maturity, receptivity for learning and the child's sense of dependence and independence as manifest in the family system. Such information includes the child's birth history, developmental milestone, pre-school care and education, past school history, past or present medical complaints or problems, parental attitudes toward the child, parental concerns about the child, parental attitudes toward the child's school and education, the child's expressed feelings about school, the child's current behaviors and socialization skills as manifested in the family and neighborhood and the child's relationship with each parent.

Finally, the social worker may explore referral to other services during the intake interview. When appropriate, the social worker discusses the availability of the Center medical consultant or Children's Medical Services and provides parents with the necessary information for making application.

The social worker formulates a social/emotional evaluation from the parent interview and presents this at the regular team staffings. Essentially, the social work evaluation relates to the family system, the referred child's position in that system and the degree of self-expression and self-esteem the child has subsequently been able to develop. The social work evaluation, while complete in itself, is only part of the child's comprehensive evaluation and therefore, from an interdisciplinary viewpoint, is a partial assessment. The comprehensive evaluation may result in placing a priority on the family assessment in relation to recommendations. On the other hand, it may be that the social work assessment is useful as a supportive supplement to other team findings.

When consulting with educational personnel, the social worker interprets parental information to determine which behavioral strengths and weaknesses the child transfers from home to the classroom. This frequently provides teachers and other school personnel with information which they can use in establishing guide-

lines for behavioral management and academic expectations for each referred child. Also, the social worker can contribute assessments pertaining to the following questions: Are the verbal and non-verbal systems at home reinforcing the child's use of various avenues of learning? 2) Are there appropriate degrees of responsibility and organization operant in the home? 3) Is sufficient time and positive attention provided the child by at least one adult to whom the child feels attached?

Another function of the social worker is to provide liaison communication and coordination. In the routine functioning of Center operations multiple situations arise which are unrelated to a specific discipline, but are situations which require a Center team member's intervention. The social worker's liaison assistance may be requested by the Center director, secretary and other team members, or may be requested directly from school or community agency personnel. Liaison may only require one contact, but frequently requires several phone calls or conferences and follow-up correspondence. When establishing collaborative procedures with other service programs, communications may be provided on a systemmatic basis by the social worker.

The following list gives some examples of the liaison activities which are the responsibility of the Center social worker:

1. To provide coordination for the Center team, especially with regard to receiving new referrals and conducting follow-up communication with parents. This is a time-consuming and demanding role which requires the application of various human relations skills including those of moderator, arbitrator, and facilitator.
2. To respond to written or verbal requests from community agencies, medical personnel or school personnel for copies of Center evaluations on closed cases, or requests for consultation about Center findings.
3. To provide referral information for parents of school-age children who are not eligible for Center services.
4. To respond to requests from community programs and medical personnel.
5. To confer regularly with medical and agency social workers regarding mutual referral procedures.

The Center social worker performs other duties common to all team members which include:

1. Case coordination.
2. Review of school history and records of previous services provided the referred student.
3. Collection of current information through consultation with school personnel and classroom observation.
4. Routine record-keeping.
5. Participation in team staffings designed to coordinate efforts and set priorities for the treatment plan.
6. Composite report writing.
7. Participation in consultative sessions with parents, school personnel, and community professionals.
8. Providing in-service training for other educators.

RESPONSIBILITIES OF THE SPEECH PATHOLOGIST ON THE INTERDISCIPLINARY DIAGNOSTIC TEAM

I. Diagnosis - The speech pathologist will assess the communication skills of each referred child, report findings, relate those findings to the total diagnostic input of the team and recommend remedial procedures.

A. Evaluation

Formal testing instruments suggested for use in a diagnostic center are listed on a separate sheet. The test battery employed is not rigid, but rather remains flexible to be tailored to suit the needs of each child. In general, areas to be assessed include hearing, speech and language.

Perhaps one of the most efficient tools of the speech pathologist is the tape recorder. At the Child Study Center, we have found tape recording to be effective as a primary technique for differential diagnosis. Both video and audio tapes are used to record the spontaneous speech activities of each child for approximately one hour. These activities might include verbal descriptions of situational pictures such as those found in the Peabody Language Kits or descriptions of various objects which they can feel, but not see. As the child relaxes in the situation, his discussion may include describing aspects of his personal environment such as siblings, pets and hobbies. Each child is always told when a recording is being made. In addition to the fact that microphones and cameras are observable, this technique often enhances motivation for the child. Some children respond to the inducement of seeing themselves "on television". Others seem to appreciate the "straightness" of dealing with them as aware participants. In any case, the children's response to this technique has been positive.

Once taping has been completed, analysis of both verbal and non-verbal recorded behaviors can provide directions for further evaluation. Taped samples can be subjected to language analysis such as Lee's "Developmental Sentence Scoring" if language level appears deficient. Problems such as poor grammar, lack of conceptual knowledge, word-finding problems are quickly evident upon review of a tape. Speech problems often appear during spontaneous speech, although not evidenced during formalized articulation testing. In addition to specific speech sound production difficulty, problems with ballistic speech movements, prosody, vocal production and dysfluency will appear in recordings of conversational speech. Phonetic transcription and voice quality can be more effectively analyzed by reviewing tape recordings than by making judgements at the time of evaluation. Finally, many non-verbal behaviors which might be overlooked under the pressure of actual assessment procedures, may be observed during tape reviews. Behaviors such as eye-blinking, increased hand or foot movement, tremor and patterns of occurence, often hold important diagnostic clues, not only for the speech pathologist, but for other team members, physicians, etc.

When a picture of the child's total communicative functioning has been obtained through taping, more specific testing of possible deficit areas can begin. With few exceptions, every child receives an audiometric screening for acuity and peripheral-oral examination. Failure on audiometric screening calls for pure-tone threshold testing. If a hearing impairment is indicated, referral to an audiologist and/or otolaryngologist should be made. The Center speech pathologist will, at this point, act as contact and liaison between school, parents, Center team and physician to interpret and discuss findings and recommendations. Examination of the oral mechanism, in addition to revealing functioning of tongue, lips, velopharyngeal structure and respiratory control, also will indicate possible neurologic involvement (depressed motility, asymmetrical movement, tremor) and health problems (enlarged adenoidal tissue, pustules, poor dental hygiene, abscessed teeth, etc.). Again, these findings have implications beyond the immediate area of speech pathology.

In-depth measurement of deficit areas includes both formalized testing procedures and diagnostic therapy to determine the extent of the problem, areas of stimulability and most effective techniques for remediation. It is well for the Center speech pathologist to review new assessment and therapy materials as they become available. In this way, a wider range of diagnostic description and remedial techniques can be offered to those persons receiving our services.

B. Integration of Information

Information obtained through the testing process must be analyzed and synthesized before a diagnosis is formulated and recommendations are made. On the interdisciplinary diagnostic team, the findings of each diagnostician are integrated to structure a composite picture of the child's learning functions. For the speech pathologist, this means that information concerning communication strengths and weaknesses should be considered in terms of their relationship to the child's intellectual status, social-emotional level, learning skills, academic level, home environment, physical state and self-concept.

Processing of evaluative findings, therefore, involves multi-level analysis and synthesis. First, the speech pathologist examines results to determine general areas of dysfunction. Once these areas are identified, analyses of the specific deficits contributing to the dysfunction(s) are made. The contributing factors are considered in terms of degree and order of influence. Then, the results are synthesized to give an overall view of the child's communicative functioning. This functioning must be given additional study to identify it's affect on the child's ability to learn and interact with his environment, as well as reciprocal influences on the child's ability to communicate.

While much of the initial testing and analysis is accomplished at the individual discipline level, the bulk of diagnostic integration takes place in team interaction. Both informally and at staff meetings, the speech pathologist discusses the nature and implications of assessment results with team members and searches for patterns and

relationships. It is at this point that identification of basic problems and establishment of priorities is made. Decisions concerning origin(s) of difficulty and areas requiring remedial intervention are considered in the team context where a total-child focus can be maintained.

The speech pathologist, therefore, must recognize and understand the interaction between skills identified within the communication process, and those which are considered by the learning diagnostician, psychologist, social worker and physician. Tests used within disciplines can be used among disciplines to substantiate or further define diagnostic judgements. Remedial techniques can be coordinated for increased multi-modal stimulation. Duplication of effort in therapeutic and instructional methods can be avoided. The result should be a complete, yet parsimonious prescription designed for the child within his total situation.

C. Reports

The Center speech pathologist is primarily responsible for two reports: the Communication Evaluation and the Composite Report (on cases assigned for coordination).

The Communication Evaluation is essentially a report of findings within the areas of speech, language, conceptual knowledge, expressive language, language interference, auditory acuity and auditory perception. This report is aimed primarily at school-based and medical specialists such as speech clinicians, audiologists and otolaryngologists who have some previous understanding of the field.

As case coordinator, the speech pathologist is responsible for integrating and condensing the entire history and evaluative findings in a case, determining and setting down recommendations as finalized by the team in intra- and inter-staff conferences, and noting significant follow-up suggestions in the Composite Report. This report reflects the whole-child approach while emphasizing major factors operating in the child's environment. Because this report is aimed primarily toward school personnel, in particular the classroom teacher, language exclusive to a discipline is avoided. Recommendations and prescriptions are designed with available school, community and family resources in mind.

Occasionally, the Center speech pathologist will be asked for supplementary reports. Some, such as a review to a Cleft Palate Team or community speech and hearing clinic, will be specifically related to the field. Others, such as a report to a psychiatrist or pediatrician, will not. In these situations, the speech pathologist can draw on the resources of team members to insure that reports are clear and appropriate.

II. Consultation - The speech pathologist will be available to act as counsel and interpreter in matters pertaining to, or peripheral to communication development and disorders with school personnel, parents, community representatives and fellow professionals.

Following evaluation and rendering of a diagnosis, the Center speech pathologist assumes the responsibility of interpreting findings with all concerned individuals and formulating recommendations for remediation of problem areas. The context of consultative activity will determine the extent of information detailed, area of emphasis, and language level employed.

A. School

Both individually and during scheduled inter-staff conferences, the Center speech pathologist relates diagnostic findings and recommendations to educational personnel. In this context, the general interest lies in the implications of a communicative disorder for the child's learning process. Usually, the Center speech pathologist will be able to work in coordination with the school-based speech clinician in formulating specific procedures for implementing recommendations. Consultation with the school-based speech clinician involves: (a) establishment of mutual respect for the competence and professional integrity of both clinician and diagnostician; (b) sharing of specific test scores, observations and theoretical considerations which influence case decisions; (c) discussion of available resources for facilitating remediation both in and outside the school.

This same process is repeated in conferences with other school personnel, although orientation will be less technical and more interpretive. Classroom teachers want information regarding effects of the disorder on overt behavior and learning style, ways of coping with and adapting for indicated deficits and specific methods or techniques which might assist in overcoming problem areas. Other school-based specialists, such as learning disabilities teachers, reading teachers and counselors, might ask to have communication findings clearly related to their areas of responsibility. They might ask for assistance in coordinating their remedial efforts with those of the speech clinician. In this case, the Center speech pathologist with an interdisciplinary orientation, could assist in designing an effective program for the total child.

B. Parents

In conferencing with parents concerning the communicative status of their child, the Center speech pathologist strives to clearly delineate and define both strengths and weaknesses, point out the present and possible effects of the child's abilities on his functioning both at school and at home and consider with the parents all alternatives available for remediation of deficits.

Very often, the parent's first question following "what?" is "why?". As far as possible, the speech pathologist explains to them factors which influence diagnosis, prognosis and recommendations in terminology which is understandable to the layman and which considers their level of comprehension and concern. The speech pathologist helps the parents become aware of resources available to them for implementing recommendations, including time involved, procedures to follow and fee structures in community agencies. The Center speech pathologist may often

act as first contact or liaison for the parents with these resources.

In all Center contacts with parents, it is important to maintain an orientation towards the parents and child as human beings rather than as a case manifesting disorders. Thus, at the Child Study Center, humanistic consultation with parents is an important strategy in the service delivery system.

C. Community

For many cases, the Center speech pathologist is called upon to relate professionally to various sectors of the community. When pediatric examination is obtained, the speech pathologist makes available to the physician a summary of communication findings which may have relevance for the child's physiologic status: for example, depressed motility of articulators, poor dental health, chronic respiratory infection, history of ear infection, dysfunctional auditory acuity. With the parents' approval, the speech pathologist may refer a child for further evaluation to a Cleft Palate Team, orthodontist or otolaryngologist. Where a community agency is already or potentially active with a child, the Center speech pathologist may discuss findings in terms of agency action in obtaining help or financial support to implement recommendations.

Within the variety of possible community contacts, the Center speech pathologist functions as a representative of both the profession and the team, and as a liaison for parents and the referring school.

III. Team Participation - The speech pathologist will accept responsibilities as a team member, for conducting procedural and coordination functions and contributing to dissemination activities.

There are many activities of the Child Study Center which do not relate to a specific discipline, but rather are general procedures to be carried out at the team level. The Center speech pathologist shares the responsibility for expediting and completing all necessary activities equally with fellow team members. Specific areas are flexible and are usually decided jointly in a team meeting.

The speech pathologist is responsible for coordinating a varying number of cases throughout the year. The coordinator assigned to each case is responsible for integrating all available written information, results of conferences and recommendations into a comprehensive picture of the child's present functioning as related to his potential, and preparing a consensus plan for remediation of any dysfunctions indicated. With some exceptions, this Composite Report is finalized following parent and school conferences.

Decisions concerning coordination are usually made at team staffings on an individual case basis, depending upon the apparent area of emphasis for each case. If, later on, the major concentration of case activity occurs in another team member's discipline (e.g., supervising a tutor, continued contact with courts, etc.) coordination responsibilities can be changed.

As part of a national demonstration/dissemination program, the Child Study Center team often receives requests for written packages, program presentations, and training workshops. Content of these various activities may refer to areas of expertise within each discipline or to the dynamics of the interdisciplinary team approach. The speech pathologist participates in the design and presentation of these packages or programs.

Clearly, the role of the speech pathologist at a diagnostic center encompasses both being a representative of a specific profession and being a member of an interdisciplinary team. This encompassing process, which occurs for all team members at various times, might be termed, "developing a balanced professional perspective". Usually, there is internal consistency between being a specialist and a team member, but occasionally there is a conflict between these two functions.

In most cases, the maintenance of a team approach is primary to establishing an effective course for remediation of a child's learning problems. However, particularly at the point where remedial strategies and prioritites are being established, the speech pathologist may act as an advocate for specific methods and techniques which are exclusive to that discipline. If a basic area appears to be overlooked or undervalued, then there is a responsibility to ask for re-examination and/or discussion at a team staffing. However, if concern moves away from efficient problem-solving and toward protection of professional status, the effectiveness of the team approach can be destroyed.

This team orientation may be initially difficult for a speech pathologist accustomed to making diagnostic judgements and developing therapy programs in the relatively independent position as an itinerant clinician. Although difficult, it is worth pursuing because total team involvement becomes an avenue for expanded insights and increased effectiveness.

APPENDICES

APPENDIX A:

STRATEGIES FOR ENHANCING PSYCHOLOGICAL EVALUATIONS*

The psychological evaluation at the Child Study Center is part of an overall evaluation which includes an educational (learning) diagnosis, a communication evaluation and an analysis of social function. One primary purpose of the psychological evaluation is to describe the child's general intellectual level and to determine if the child has potential for greater academic achievement. Diagnosis in areas such as minimal brain damage, social maladjustment and behavior deviation become a joint effort of the CSC team; however, data from the psychological evaluation is critical to the effort.

The psychological evaluations for most referred children include administering an individual intelligence test, usually the Wechsler Intelligence Scale for Children (or WISC-R), and the Bender-Gestalt. The Center psychologist prefers to use all of the Verbal Scale subtests (6) and five of the Performance Scale subtests of the Wechsler in the evaluation. Also, the Center psychologist has found that omitting any of the Bender-Gestalt designs is a false economy and he holds each card forcing the child to orient himself to the task.

Observing the child's behavior during the examination period yields valuable data which can enhance interpretations. The Center psychologist has found that he observes more effectively when sitting to the child's side or at a corner of a table rather than across from the child. When observing in this manner, the child is less likely to notice that his behavior is being closely monitored. When testing the child, the examiner observes the child's reactions to the oral directions as they are made. The examiner attempts to explore questions which may provide diagnostic information.

A description of data which may be obtained from the WISC-R follows. The reader is cautioned about the use of non-standardized administrative approaches and interpretive procedures which could result in obtaining invalid results. The purpose of the test must be determined by the qualified administrator.

1. Information - This sub-test tends to measure facts gained from daily experiences, as well as how well one can recall or retrieve such information. High scores may reflect a value for knowledge, an enriched environment and a good retrieval system. Low scores may reflect the opposite. The child's "inability" to retrieve a fact may be checked by using a multiple choice answer or by feeding a lead to see how it's handled. ("How many days make a week?", on the answer of "five", have child name all the days of the week to

*Don A. Wakeling, Psychologist at the Child Study Center, has developed this written description of strategies to share with other psychologists interested in evaluation as an observational process.

see if 7 or 5 are given; then ask, "How many days in a whole week?". On, "don't know", who discovered America, ask "Which of these five? ...DeSoto, Ponce de Leon, God, Columbus, Kennedy", for example. Does the child answer as soon as you say Columbus or did he wait? If he waited, why? What hypotheses are you forming?)

When early errors occur in combination with later passes, it is important to question if rapport had been established or if emotional factors such as anxiety or hostility had been inhibiting performance.

2. Picture Completion - To succeed the child must visually concentrate upon the pictures and identify missing parts based upon memory and internalized cues. It is necessary for the child to use an organization process to establish the absence of a missing part. For example, a child may figure out that the spots on a card should match the number although he has never been allowed to play cards.

   Performance on this sub-test is correlated with performance on visual tests administered by other diagnosticians and contributes information regarding word-finding, aphasic-like difficulties in that the missing part may be consistently pointed to, but can't be named. Also, low performance may suggest an orientation problem since misnaming often occurs with this type of difficulty.

   A low score could reflect anxiety or poor attention; whereas, a denial (nothing missing) may be indicative of fear or negativism. In addition, low scores may be associated with a lesion in the left hemisphere of the brain. Possible reasons for low scores should be studied by the examiner before proceeding with the other sub-tests, particularly if a wide intra-test variability exists on both Information and Picture Completion.

3. Similarities - The Center psychologist has found this sub-test to be the best single sub-test to measure thinking ability. Often the ceiling (three consecutive failures) has been ignored to see how the child perceives relationships. Upon careful observation of children who tended to deal with concrete objects rather than abstractions, it was observed that an almost aphasic-like functioning seemed to exist; e.g., "iron" seemed to be used in frustration to describe how two objects, one copper and one steel, were alike. Also, some children think, "bicycle", not wheel, when asked, "how are a wheel and a ball alike?" Thus, a child's ability to generalize experiences and think abstractly is measured by this sub-test.

   Sometimes perseveration responses by the child, particularly in the use of concrete descriptive terms, can be broken with a leading question such as "What are they?" when later returning to easier items. Potential allowances in scoring can be made accordingly, if the child is able to continue with more abstract responses on the harder items.

   Although this sub-test is not so constructed, it can offer the psychologist clues as to how a child may respond in a one-to-one learning situation.

4. Picture Arrangement - PA measures the ability to evaluate and understand a total pictured situation presented much like a disordered comic strip.

   The child must visually concentrate upon each picture, retain a symbolic impression, visually and/or auditorally, then rearrange the pictures while "seeing" relationships and anticipating the consequences or outcome of the pictures and story. Sometimes a child may talk to himself in an attempt to improve his performance.

   Since success requires organized thought processes, an indication of the child's adaptability and study habits might be revealed. The examiner may wish to note the following - Does the child look back over his "final" order before stopping? Does he place each picture after careful study of all pictures? Does he use one hand, or both? What kind of planning ability is used? Does he decide himself? Does he look for your approval?

   A significantly lower score on P.A. may reflect a lack of consistent emotional control but when occurring in combination with other data from the Bender or observed behaviors may suggest neurological involvement.

5. Arithmetic - This sub-test is orally administered and the child works the problems without paper or pencil. It measures alertness, attention and concentration as well as the ability to mentally and manually manipulate numerical symbols and relate to them in the proper sequence. (Is the child using his fingers, touching his nose? Do his hands disappear under the table?)

   Academic motivation, attitude toward school and even anxiety effects performance. Since the ability to use abstract concepts of numbers is basic for American education, high scores may reflect positive attitudes toward school achievement and low scores may reflect a negative attitude. Hence, there is a significant positive correlation between the occurance of low scores on this sub-test and eventual dropping out of school and in-school behavior problems.

6. Block Design - On the Block Design sub-test the child must carefully look at the picture, analyze the whole and break it down into parts. Then, he motorically reconstructs (synthesizes) the design using visual discrimination and sequencing skills.

   This process becomes increasingly more complex after number four of the sub-test. To achieve average or above average scores the child must be able to see patterns and spatial relationships and be able to shift or change (inhibit action/energy) as needed.

   Low scores may be indicative of a disturbance in perceptual functions, problems of an organic nature or emotional factors; e.g., anxiety or disinhibition may cause rotation of two blocks at a time.

   High scores do not rule out the possibility of organic problems as it is hypothesized that Block Design performance essentially requires the functioning of only one hemisphere. Similarly, it should be noted that reading is also hypothesized to primarily involve only one hemisphere.

If a child succeeds when provided pictured designs showing four blocks (through number four) then fails subsequent items, the examiner may wish to later use blocks to make a design, such as number 6, then see if the child can copy the pattern offered. Success at this point may indicate that the child can synthesize but not analyze the design.

7. Vocabulary - Vocabulary shows the quality of thought processes as measured by verbally expressed word knowledge that has been gained through the individual child's total experience including formal education.

   The early labeling and symbolic thought processes are reflected through the child's expressed definitions. At times, a single word answer may have potential to be scored 2 points if the examiner follows up the seemingly infantile or poor response. (Umbrella-rain, clock-tick tock, nail-bam). Follow-up is recommended if your purpose is to measure the child's potential for learning in his population rather than being interested in only comparing the child's responses with those of a standard population.

8. Object Assembly - This is a visual-motor perceptual task without an overt pattern to guide the child and is akin to jigsaw puzzles. The child must discriminate the whole from the parts and make the whole while continually organizing the whole to part relationship. This differs from the advanced block designs that require breaking the whole down into parts before rebuilding the whole. Scores obtained by some minority children are higher on Object Assembly when compared to other WISC sub-tests suggesting that cultural factors may be less influential on this sub-test.

   Can the child perceive the whole? If so, is he unable to make it? Low scores may be indicative of organic problems, poor planning ability or poor persistence.

   Some observational cues follow: Does he touch his own face to "see" where his nose is? Does he ask for help? Why? Did you ask him why he asked if you aren't sure? How does the child react to mistakes or inability to place the piece? Does he ask you for help, knock it off the table, or rigidly use the same approach? How flexible is he? How free is he to explore? Observe how motoric skills effect performance. Does the horse differ from the other that have linear clues as well as shape?

   If you have a "rigid" child and the face is correct except for the eye with the eye being held firmly by one hand on the face, you can simply remove it after time has elapsed and say, "now" or "now try it", and note how the child reacts (with suspicion, embarrassment, relief, etc.). The child's response may indicate how he handles "insight".

9. Comprehension - Social judgement and ability to attend to the verbally presented problems are measured in this subtest. Regardless of experiential background, higher scoring children are able to figure out appropriate answers via an ability to organize the facts, see relationships and produce a relevant answer.

Since children who verbalize less well and children with limited contacts may make lower scores, caution must be used in concluding that a low score reflects poor intellectual potential. Rather, the low score may reflect an inability to adequately use potential.

Performance on this subtest may yield fruitful hints or leads for follow-up. For example: How dependent is the child? How does he cope? Is he preoccupied? Are his responses out of context?

10. Coding - Coding is a paper and pencil task akin to some tasks the child may have been asked to do in school. The child is required to associate one set of symbols with another (numbers) and use motor coordination of both hand and eye. Dexterity is a major factor. Since this is a timed test, the degree of precision in responding is important; i.e., precision may cost the child in score obtained. Memory/learning is a factor as the test progresses and the examiner should be in a position to observe the child's eyes to see if they move back and forth or if he is remembering.

    One of the more frequent factors observed is the lack of attention to directions or the inability to hold the directions in mind. As the child ends row one (he has been told to go on) he may stop, pause, or ask for permission to go on (verbally or via an expression). The examiner should establish his own methods of handling this and score accordingly. Duly noting the pauses, the Center psychologist always scores those completed in 120 seconds of work on the task. The test is formally omitted for children with serious organic problems.

    This sub-test reflects how well a child can accept a challenge on a paper and pencil task of this type. Clues are obtained about the student's ability to copy materials required in some classes.

    Interpretive caution should be used if WISC-R directions and forms are not used. The WISC-R subtest seems to measure a different thing than the WISC! It has been noted by the Center psychologist that apparently some former problems such as the copying of numbers rather than symbols under the numbers or the copying of the sample area over again have disappeared when WISC-R procedures are used.

11. Digit Span - This sub-test has been one of the most valuable single tests as it requires attention, concentration and (immediate auditory) recall. A low score may reflect a phonics, attention, health, hearing or memory problem. Since scores on this sub-test are positively correlated with later measures of progress of those children participating in the Center program, it is hypothesized that this test may have value as a predictor of remediation success.

    An inability to shift according to the directions may be revealed when a child succeeds with forward digits but fails with reversed digits. The examiner can test this hypothesis by using his fingers to provide a visual example; e.g., 1-2-3, then reversed 3-2-1. Conversely, when children are more successful with reversed digits, this may be indicative of high stress tolerance.

12. Mazes - This sub-test has not been used consistently at the Center. In order to measure the child's manual execution of a visually seen pattern, the child must be able to attend to directions. The Center psychologist has been interested in observing each child's acceptance of this "fun" test as it gets harder. The following are observed: Does he look at the examiner? Does he need encouragement? What does he do when an error is made?

BENDER-GESTALT

The Bender is used by the Center psychologist not only to obtain reproductions of the designs, but as an evaluative process (which needs to be observed). The following guidelines are presented for each card to facilitate more effective interpretations of performance on the Bender.

Card A. Left to right orientation and directionality are noted. If a sketching approach is used, later inquiry may be desired to determine if this approach is a reflection of anxiety or training. Look for signs of "dog-earing" on the rotated square. A reversing in the position of the designs is generally due to an upside down presentation to the child by the examiner although a vertical representation should be followed up. If the designs do not touch, what might this mean? Changes in pressure may be noted here giving a lead for further observations during the test. Was it drawn in the center of the page? Card A may be presented again as the last card to see the verbal, facial, or other recognition indicators.

Card 1. An incomplete or sloppy reproduction may reflect poor study habits, inattention to detail, inability to maintain attention on the task. Neurological involvement may be suggested by slashes or circles although these seem to be present in some children without other signs such as rotations and trouble with line change of direction. Counting is noted. Does he ask the examiner first about the number? Does the head bob? Does he point (watch out for the pencil on the card as marks are a no-no)? Does he look, count and then draw or look, count aloud, draw, re-count, draw, count, etc., on and on? The grouping effect may be significant in older children.

Card 2. Directionality and attack on the task can be noted. Does he count all or "see" the three and count those groups? Does he remember or re-count as on Card 1? Is the angle of the columns seen and drawn? Are circles, dots or ovals used? Check directionality again. Are reproductions carefully lined up under number 1? Does the child's drawing go up hill? Does he spread the three circles apart as he continues? Is the child apt to give the teacher a neat paper in a class setting with less supervision than on the Bender? How is he apt to respond to authority figures, rules, etc.? Are you starting to get a hunch as to how the child will handle the WISC: P.A., B.D., or Cod., for example? Has perseveration from

number 1 continued?

Card 3. Perseveration may be noted here also with the one dot often drawn followed by a series of threes as in card two. The child's expression or head movement may help confirm the fact that he is aware of an improper reproduction but did nothing about it. If the angles are not drawn (or noted upon inquiry later if necessary) the child may indeed be unable to attend to details needed in educational procedures. If rotations occur, find out why. (Christmas time brings a lot of "neurological" signs if you don't check on why a "tree" was drawn.)

By this time the psychologist should be formulating a hypothesis as to sensory/central/motor involvements if they are suspected.

Card 4. This card is the first "solid" line figure following three "dotted" figures. Many aspects of Card A can also be seen here such as orientation, directionality and touching of designs. Is the line quality consistent? Does a peak occur on the curve? Does the child appear relieved after coping with the previous dotted figures? By now some hypothesis as to emotionality and neurological maturation should be formed by the examiner.

Card 5. This card is a return to a dotted figure that is harder to count or group. Do you need to repeat your instruction to draw it exactly as it is on the card? Why? Did he ask a question, look frantic or start to use solid lines? Is ther a compulsive need for exactness? Is there a need to use his finger or pencil to count or keep his place? How even are the bottoms of the curved line? It is very important to observe how and when the straight line is drawn. If drawn first and toward the child, it may be an indication of present or potential impulsivity to be explored in conferences with parents and school personnel.

Card 6. This figure is a return to a solid line figure involving a precise change of direction, position for the crossing of the lines and size of the wavy lines. When a child draws very rapidly, without care, it may be an indication of the approach to paper and pencil tasks that is usual for him; if the reproduction is indicative of neurological dysfunctioning, be careful of the interpretation until you have more data, or until he tries again more carefully (at the end of the test). Watch for pauses or slight distortions or over compensations at the peak and trough of the curves. Compare the reproduction of Card 6 with that of Card 4. How carefully are four full curves drawn "horizontally" and three and a half "vertically"? (Note the slight neurological overcompensation on the "vertical" line on your card? I don't recall it on the earlier cards or was I less observant?)

Card 7. Here the child has the only overlapping figure on the Bender. If Card A and Card 4 have shown fusion or some absorption, the results of this design should be studied carefully. The newness or shock of the Bender task has about ended. More precision may be attempted. Body and head rotations may occur. If a separated overlapping figure is produced, talk about this drawing upon completion of Card 8. If "seen" properly, can the child tell you why he drew

it as he did? Did the child note the heavier left design or the poor "corners"? (Actually the poor printing job on the stimulus card may be helping us diagnostically!) If a sketchy approach is used, check later about art interests or possible instruction that may be contributing to this approach. Again, watch that speed does not "cause" neurological or other interpretations here. Often a "dog-earing", where the designs overlap, may be an attempt to correct, rather than a problem in the neurological area. (What was done on Card A and Card 4?) Occasionally, there will be an overcompletion or need to add lines to these figures (as making triangles at the end of each design); was the reproduction of Card 5 closed also? Was it done after you removed the stimulus card?

Card 8. This design will tend to add weight to previous hypotheses the examiner may have formed. Some distortions may appear, as on Card 7, that may be related to the felt physical status of the maturing male although the significance of this is questionable. The reason for the oversight or omission of the diamond should be determined by the examiner. Often a quizzical look by the examiner will bring a "spontaneous" addition.

The Center psychologist usually starts the inquiry by asking the child to tell him what changes would be made to make the drawings just like those that were seen. After the child has made the few remarks he wishes to make, the psychologist has the child direct his attention to specific designs.

APPENDIX B: EVALUATION INSTRUMENTS

MATERIALS FOR LEARNING EVALUATION:

_____ 1. Detroit Tests of Learning Aptitude
_____ 2. Illinois Test of Psycholoinguistic Abilities
_____ 3. Key Math Diagnostic Arithmetic Test
_____ 4. Wide Range Achievement Test
_____ 5. Gilmore Oral Reading Test
_____ 6. Peabody Picture Vocabulary Test
_____ 7. Frostig Developmental Test of Visual Perception
_____ 8. Bryant Test of Phonics Skills
_____ 9. Roswell-Chall Diagnostic Phonics Test
_____ 10. Kottmeyer-Ware Diagnostic Phonics
_____ 11. Keystone Visual Survey Tests for the Telebinocular - also
  _____ a. Ready-To-Read Tests
  _____ b. Rapid Vision Screening Tests for Schools
_____ 12. Vane Kindergarten Test
_____ 13. Gates-MacGinitie Silent Reading Test
_____ 14. Lee-Clark Reading Test
_____ 15. Pupil Progress Series Diagnostic Reading
_____ 16. Spache Diagnostic Scales
_____ 17. Harris Test of Laterality
_____ 18. Kinesthetic Blocks
_____ 19. Ayers Test
  _____ a. Body Parts
  _____ b. Body Visualization
  _____ c. Right-Left Discrimination
_____ 20. Huelsman Word Discrimination Test
_____ 21. Informal Instruments
  _____ a. Motor Maze
  _____ b. Pictures
  _____ c. Word Forms
  _____ d. Designs
_____ 22. Van Waganan Visual-Visual Word Learning Test
_____ 23. Van Waganan Word Discrimination Scale
_____ 24. Alphabet
  _____ a. Recognition
  _____ b. Writing

PSYCHOLOGICAL EVALUATION:

_____ 25. Wechsler Intelligence Scale for Children
_____ 26. House-Tree-Person
_____ 27. Stanford-Binet L-M
_____ 28. Ammons Full Range Picture Vocabulary Test
_____ 29. Ammons Quick Test
_____ 30. Bender Visual-Motor Gestalt
_____ 31. Memory for Designs
_____ 32. Coordination Activities
_____ 33. Psuedoisochromatic Plates

PSYCHOLOGICAL EVALUATION (Continued):

_____ 34. Three Wishes
_____ 35. Sentence Completion
_____ 36. Thematic Apperception Tests
_____ 37. Rorschach Ink Blot Test
_____ 38. Draw-A-Person

SPEECH & HEARING EVALUATION:

_____ 39. Templin-Darley Tests of Articulation
_____ 40. MacDonald Deep Test of Articulation
_____ 41. Goldman-Fristoe Test of Articulation
_____ 42. Fisher-Logemann Test of Articulation Competence
_____ 43. Screening Test for Auditory Perception
_____ 44. Goldman-Fristoe-Woodcock Test of Auditory Discrimination
_____ 45. Lindamood Auditory Conceptualization Test
_____ 46. Utah Test of Language Development
_____ 47. Developmental Sentence Scoring
_____ 48. Boehm Test of Basic Concepts
_____ 49. Engelmann Basic Concept Inventory
_____ 50. Northwestern Syntax Screening Test
_____ 51. Houston Test of Language Development
_____ 52. Hiskey-Nebraska Test of Learning Aptitude
_____ 53. Test for Auditory Comprehension of Language
_____ 54. Verbal Language Development Scale
_____ 55. Sklar Aphasia Scale
_____ 56. Peripheral-Oral Examination
_____ 57. Audiometric Assessment

_____ 58. OTHER: _____

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APPENDIX C: SOME REFLECTIONS ON THE GROUP REMEDIAL PROGRAM

Joy Landau

Out of the experience of participating in the Group Remedial Program from February to May of 1974, the following observations seem worthy of further exploration and crystalization. Some of these are recommendations and some are guidelines that can be shared with others interested in what we have learned from the children. These comments have emerged from my own perceptions of the purpose and need for having a prototypical psychoeducational class within the context of the Child Study Center model.

* * * * * *

Select children from grades 4 and 5 for participation in the Group Program. Plan several observation periods at each child's home school prior to placement in the group. During the observations note the following points for the purpose of setting priorities for changing behaviors and for defining short term goals:

1. How does the child interact with his teacher and his peers?
2. What environmental factors provoke the child?
3. What environmental factors soothe the child?
4. What signals does the child send out regarding his style of learning, his tolerance for frustration and his feelings about himself?
5. What sparks his curiosity and stimulates him?
6. Does he have any outstanding physical characteristics such as a high energy level or a complex of bodily movements he unconsciously adopts when under stress?
7. Can he work independently?
8. At what can he succeed?
9. At what does he fail?
10. What does he consider fun?
11. Who are his friends?
12. What is his regular schedule or routine?
13. What reading and math books is he using?
14. What is his teacher's attitude toward an interchange of ideas and strategies for the purpose of helping the child?
15. What are the parameters for change within the school environment so that positive suggestions can be offered at the soonest?

Based on information gleaned during the formal evaluation process, conferences with school personnel and observation of the child in different settings, screen out children whose needs are primarily of an emotional nature from those whose self-concept and interactional difficulties are more interwoven with learning problems.

Begin with 8 to 10 children to allow for intensive interaction and the development of personal rapport between the teacher and the child. Feed in and out other children for diagnostic purposes or for flexible periods of remediation after the core group is stabilized. The time initially put into relating to the child as a whole person and not just as a student will pay off later in academic dividends. Of critical importance is the consideration of the child's own time frame rather than an artificial construct of how fast others feel the

child should be changing.

In the past, the child's negative behaviors may have been a call for help, but when we let him know that help is coming, the child may find it scary to be in the spotlight and become frightened or ambivalent about help. Three stages of development (the duration of each being unique to each child) occurred with many of the children who participated in the Group Program:

1. "Stay away from me and leave me alone --- I don't want to change and I won't let you get close to me (even physically)."

2. "Okay, I'll show you my worst behaviors and let's just see if you really want to stick around me."

3. "I guess you accept me so I'm going to start to unload and you better be there when I need you."

Some of the children obviously had been bruised significantly by their family experiences and school difficulties. Out of respect for the child's insult, we must commit ourselves to moving at the child's pace and to providing the support and nourishment necessary to help that child move toward greater health and accomplishment or not offer ourselves as an initial resource at all.

Coordinate the Group Remedial Program effectively with our own Child Study Center specialists so that appropriate and effective therapeutic help may be offered to the children on an individual and/or small group basis and to the families of the children when necessary.

The initial step in establishing a Group Program is to create a fundamental life context into which the child is integrated since a major difficulty for most of the children is in their ability to relate and interact appropriately with people and situations and to correlate their personal realities with any larger reality. Only after there is a context in which the child becomes aware of the very concepts of values, responsibility, appropriateness of interaction, only when he begins to recognize that he is functioning within a framework of reliable and understandable limitations and potentials, only then can he begin to make significant academic progress.

Begin with a highly structured environment in both a physical and psychological sense. Provide an objective framework to which everyone can relate and come together; provide feedback in the form of definition of boundaries and limits, expectations and consequences. Consider setting up a list of behaviors with resultant consequences so that as "testing out" behaviors occur, they can be dealt with consistently and unemotionally within a fundamental stability. Be restrained and slowly feed into the system increased responsibility, demands, privileges and flexibility in consonance with the children's ability to handle them securely, striking an efficacious balance between what is immediately desirable and what is ultimately possible.

Within the structure, program revisions and the development of strategies can be immediately tested for effectiveness.

Strive to establish regular and frequent contacts with the family and school personnel of each child in the Group. Children want an open flow of communication and will strive to activate more than lip service to this principle. Strategies which can be useful include personal or telephone conferences; "happy notes" home and to school; round robin notes on which teacher, resource

teacher, parent and child add their own comment to "Today I liked it when Johnny..."; participating in an activity which is out of usual context with the child. A child needs to hear from all those around him the same kinds of messages that he is of value and cherished and that those around him are interested in and take pride in his accomplishments no matter how small or fragile they may be at first.

Use positive reinforcers that are meaningful to the children. When rewarding behaviors, provide relevant feedback to each child about what you like in him, what behaviors are appropriate in different situations and what behaviors will result in the positive attention the child is seeking. For children who evade circumstances which place any demands or stress on them or for those who refuse to participate or perhaps even acknowledge the existence of their environment, a systems approach of positive reinforcers and consequences might be most beneficial to break rooted patterns. A corollary benefit of a systems approach is that it helps the adult put his own emotions into perspective by providing responses previously set up, allowing him to hear the children's messages rather than his own. In working with the children in the Group Program it was clear that we had to move slowly from individual to group activities both in terms of the time continuum of the whole program as well as the daily time schedule. The concept of self had to be developed before we could ask a child to be aware of others. Only after a child had a backlog of small successes and a growing internal storehouse of pride whould he risk bolder challenges. Strategies to focus attention on positive behaviors might include awarding of points toward a stated reward or a choice of how to use time; a merit system with a built-in graduation of rewards, privileges and responsibilities; performance graphs for work completed and accuracy of work completed; frequency of behavior charts posted in view of everyone; self-evaluations on a daily basis; problem solving sessions; establishing codes between the teacher and child to gain attention or to signal distress before it overwhelms; activities to stimulate reflective listening and to increase positive feedback from the child's peers.

Within this setting where a child can progress at his own rate without undue pressure and with the experiencing of success, the curriculum should provide for nourishment of the child in four areas:

1. Controlling one's own behavior through cognitive choices of appropriateness and responsibility.
2. Communicating to others and developing the willingness to trust.
3. Getting along socially with one's peers and seeing oneself as a competent, worthy person.
4. Succeeding at appropriately selected academic assignments and profitting from remedial help.

Some specific skills and awarenesses which should be developed in a functional sense along with pinpointed academic skills include the handling of time, learning to pace and balance oneself, to relax and to concentrate, attending to stimuli, organizing one's environment, making choices, following oral and written directions, organizing and manipulating sensory input, developing strategies for dealing with tasks, understanding the principles of cause and effect, action and reaction and stimulus and response.

In developing individual prescriptions and schedules, it should be remembered that independent work requires self esteem. Most of the children who participated in the Group Program were at the "show me I'm of value" stage and thus

were very people-oriented. Although teaching machines were of value by virtue of being low-keyed and immediately reinforcing in some cases, it was my observation that the children who were most deprived in their own lives of a stable involved relationship with an adult or adults shunned machines the most. When these children were able to handle a machine after their self-esteem had increased, they still were more receptive to teacher-produced tapes than to commercial tapes.

Once an individualized prescription has been developed, attention must be given to how this can be interwoven into the classroom setting. This is crucial not only within our own program but also in helping the child's regular classroom teacher benefit from the data gained from the diagnostic evaluations. For many children with learning and behavioral problems, giving them work that is at their level of functioning is simply not effective by itself. The problem has become much more than an academic one; it is rooted within the child's whole mode of interaction with all of life.

Finally, stability in structure must be reinforced by an efficient and predictable method of transporting the children to the Child Study Center so that time can be utilized where it is most needed. If the driver is to also serve as a classroom aide, he must be given guidelines and support in his dual role.

APPENDIX D:
CLASSROOM GUIDELINES FOR FACILITATING LEARNING

1. Know yourself as a learner so you can separate your own ways from the child's learning style.

2. Communicate genuine caring, maintain a supportive and non-threatening emotional atmosphere; nourish the child's ego.

3. Smile; be positive. Catch the child being good. Point out to the child what he does that is appropriate and that you like; give positive feedback to the child.

4. Praise little steps toward ultimate goals; reinforce "successive approximations".

5. Handle problems with appropriate emotion; reassure the child by demonstrating that you are in control of your emotions. Own your feelings and specify the behavior toward which these feelings are directed.

6. Establish positive expectations; spell out appropriate behavior in each situation.

7. Set understandable limits and logical consequences for behavior. Use natural consequences, constructive confrontation, problem solving strategies and other non-punitive approaches to maintain stable limits.

8. Be consistent so that the child can come to have the security of knowing what responses to expect. This will help phase out some "testing" behaviors.

9. Give a child the opportunity to test out the same situation until he learns to handle it. Stress that the child choses the consequences that will result by his behavior.

10. Rather than reminding a child what he has done wrong in the past, start off fresh each time and deal with the here and now. When rules are broken in defiance of authority, try to read a behavior as coming from a legitimate desire to meet a need.

11. Ignore a restless behavior if it is non-disruptive and of short duration.

12. Alternate periods of concentration with periods of movement; opportunities for movement will help channel excess energy. Use opportunities for movement as a reward for productive behavior and as an intervention technique before restless or inappropriate behavior begins.

13. Anticipate a child's frustration level and move in before he reaches the point of explosion.

14. Teach attention, control, and study skills as learning objectives. Slowly increase abilities through use of a timer, positive reinforcement, appropriate tasks and praise.

15. As a child gains in control over himself, your expectations should increase but remain realistic to his abilities at the time.

16. Use a "time out" area when a child needs to calm down. Set a specific time using a mechanical time or until the child can commit himself to following the existing rules.

17. Structure the learning situation as concretely as possible.

18. Reduce the number of distracting stimuli whenever and wherever feasible. (Use a cardboard study carrel, "quiet corner", earphones to screen out extraneous noise.)

19. Initially break down units of learning into the smallest possible steps. Be aware of what you are asking a child to do. Make the child aware of the specific task requirements.

20. Use a multi-sensory approach to learning.

21. Apply the theory of "overlearn" to establish patterns of procedure and reliable responses.

22. Develop strategies to meet each child's learning style.

23. Control the amount, rate and speed of input.

24. Make sure materials are appropriate to each child's physical, perceptual and academic abilities.

25. Teach through the child's strengths while developing his deficit areas.

26. Differentiate between teaching and testing in setting up activities.

27. Set priorities for developing an individualized program and establish a progression of expectancies.

28. Constantly be observing the child's behaviors for diagnostic clues. (Auditory learner who needs to verbalize on visual tasks; visual learner who closes eyes to concentrate on auditory input and construct his own visual image; discern behavior patterns which precede an explosion.)

29. Keep daily performance records to show progress. Display in a prominent place. Involve the child in the record keeping.

30. Talk to a child and give him the knowledge that he has certain tools or strategies that are effective for him. He needs feedback on how he learns best in order to compensate while remediation is ongoing.

31. Spend less time "talking at" and more time "listening to" students.

32. Accept, clarify and use student ideas, attitudes and questions to personalize learning activities.

33. Commit yourself to the best use of the time you have with a child. Ask yourself to be the best that you can just as you ask it of the child.

APPENDIX E:
CENTER FORMS, REPORTS AND RECORDS

Attached are Center forms used, either during the first three years of Center operations or currently during this fourth year:

Form Number	Description
1	Order of materials in Center file
2	Referral forms for Pupil Services Division
3	Service Record
4	Coding for Child Study Center Objectives
5	Letter to parent re: scheduling of child
6	Memo to school contact person re: transportation of child
7	Individual Report - Communication Evaluation
8	Individual Report - Diagnostic Learning Evaluation
9	Individual Report - Psychological Evaluation
10	Individual Report - Social/Familial Evaluation
11	Composite Report with title page
12	Memo re: Composite Report at time of forwarding to school
13	Center Staffings

The following forms were used during the first three years of Center services:

Child Study Center request for services

Parent Rating Scale

Cover Letter for Parent Rating Scale

Teacher Rating Scale, Form A

Teacher Rating Scale, Form B

P I N E L L A S C O U N T Y S C H O O L S Y S T E M

Permission for Services

RE: _____ SCHOOL: _____

PRINCIPAL: _____

In order to aid us in planning and providing a better educational program for your child, we would like the Child Study Center, Title III personnel to evaluate _____. In addition to educational specialists, Center personnel includes a psychologist, social worker, and speech pathologist. There is no fee for this service as it is part of the many additional services offered to children by your school system. However, this service can only be provided to children with parental consent.

Would you please sign this form if you wish this evaluation.

The Pinellas County School Board Personnel at the Child Study Center have my permission to see my child.

_____
Parent(s) Signature

_____
Date

Address: Child Study Center
All Children's Hospital
Children's Services Center
801 6th Street South
St. Petersburg, Florida 33701

Phone: 821-5260

CSC 8/74

P I N E L L A S C O U N T Y S C H O O L S Y S T E M

CHILD STUDY CENTER

Release or Receipt of Information

Permission is hereby given to the Child Study Center, Title III, Pinellas County Schools, to send to and/or receive from any professional agency or person information concerning _____ which would aid in education planning for him or her.

_____
Parent(s) Signature

_____
Date

CSC 10/72

Date

Name
Address

Dear (Parent or Guardian):

We are writing to let you know that (NAME OF CHILD) has been scheduled for evaluations by the Child Study Center team on (DATES). Additional evaluations will be scheduled as necessary. Generally, evaluation periods last from 8:30 A.M. to approximately 11:30 A.M.

For each evaluation, a Center employee will be available to provide transportation for your child from the school to the Center and back to school again. Please check "yes" or "no" regarding Center transportation and return this letter to the Center in the enclosed envelope.

The Child Study Center has my permission to transport (NAME) to the Center for any evaluations scheduled.

_____ YES _____ NO

Parent's or Guardian's Signature _____

If you wish to contact the Center, our telephone number is 821-5260.

Sincerely,

Case Coordinator

cc: Counselor
School

CSC 5/75

MEMORANDUM (Date)

TO: (Name) , Counselor
(School)

FROM: Child Study Center Personnel

RE: Students for Transportation for Services

Please have the following student(s) in the office by (TIME) on (DATES) for transportation to the Child Study Center for evaluation. Thank you.

(LIST)

CSC 5/75

COMMUNICATION EVALUATION

NAME: SCHOOL:

D.O.B.: GRADE:

EVALUATION DATE: EXAMINER:

I. STATEMENT OF PROBLEM

II. OBSERVATION

III. CASE HISTORY - see Social Work report

IV. EVALUATION

V. DIAGNOSTIC SUMMARY

VI. RECOMMENDATIONS

CSC 5/75

DIAGNOSTIC LEARNING EVALUATION

NAME: EVALUATION DATE:

D.O.B.: SCHOOL:

AGE: GRADE:

I. OBSERVATIONS

II. FINDINGS

III. SUMMARY

IV. RECOMMENDATIONS

V. SUGGESTIONS FOR INSTRUCTION or APPENDIX

_____

(Name)
Educational Diagnostician
(Date of Report)

CSC 5/75

PSYCHOLOGICAL EVALUATION

NAME: CHILD STUDY CENTER

D.O.B.: EVALUATION DATE:

AGE: SCHOOL/GRADE:

I. EVALUATION PROCEDURES

II. FINDINGS/OBSERVATIONS

III. DIAGNOSTIC SUMMARY

IV. RECOMMENDATIONS

_____
(Name)
Psychologist
(Date of Report)

CSC 5/75

SOCIAL EVALUATION

Date of Parent Interview:

I. IDENTIFICATION

(Name) D.O.B.:
(Address)
(City, State) Phone:

Grade: School:

Family:

II. SCHOOL HISTORY

III. DEVELOPMENTAL HISTORY

IV. BEHAVIORS AT HOME

(Including Parents' specific concern and estimation of child's learning problems.)

V. DIAGNOSTIC IMPRESSION

(Name)
Social Worker
(Date of Report)

CSC 5/75

COMPOSITE REPORT

I. IDENTIFICATION

Name
DOB
Parents
Address
Phone
Siblings
School
Grade
Referred By
Evaluation Date
Case Coordinator

II. REASON FOR REFERRAL

III. PREVIOUS SERVICES

IV. CENTER FINDINGS

V. DIAGNOSTIC SUMMARY

VI. RECOMMENDATIONS

VII. FOLLOW-UP

APPENDIX - Specific Instructional/Behavioral Suggestions

CSC 5/75

PARENT RATING SCALE FOR CHILD'S BEHAVIOR

Child's Name: _____

Age: _____

Parent(s) or Guardian(s) Name: _____

_____

Date: _____

Directions: Please mark an (x) under one of the headings opposite each behavior.

	Never or Rarely	Sometimes	Frequently	Almost Always
1. Performs responsible routine chores.	___	___	___	___
2. Completes whatever he/she is doing.	___	___	___	___
3. Accurately follows directions.	___	___	___	___
4. Adapts readily to change.	___	___	___	___
5. Concentrates on an activity even in a noisy situation.	___	___	___	___
6. Attends, listens when someone talks to him/her.	___	___	___	___
7. Talks about things that happen at school.	___	___	___	___
8. Shows the ability to identify body parts and functions.	___	___	___	___
9. Answers questions accurately.	___	___	___	___
10. Uses hand signs, body signals, or noises in place of words; avoids speaking.	___	___	___	___
11. Shows self-control when necessary.	___	___	___	___
12. Says things which tell he is proud of himself.	___	___	___	___

Parent Rating Scale for Child's Behavior (Continued)

	Never or Rarely	Sometimes	Frequently	Almost Always
13. Acts without thinking.	___	___	___	___
14. Becomes angry easily.	___	___	___	___
15. Attends school regularly.	___	___	___	___
16. Gets along with children around the same age as he/she is.	___	___	___	___
17. Gets along with parents.	___	___	___	___
18. Gets along with brother(s) and/or sister(s).	___	___	___	___
19. Damages or destroys things belonging to others.	___	___	___	___
20. Health Habits:				
Has good appetite.	___	___	___	___
Goes to sleep and wakes up at appropriate times.	___	___	___	___
Takes care of body cleanliness.	___	___	___	___
21. Complains of headaches and/or stomachaches.	___	___	___	___

Is your child taking medication under a doctor's supervision?

TEACHERS' RATING SCALE FOR PUPIL BEHAVIOR

Pupil's Name: _____

Rater's Name: _____

Date of Rating: _____

FORM A (Grades K - 3)

Directions: Rate this pupil's behavior from "1" to "5" for each behavioral description by placing an "X" on the selected numeral. A rating of "1" indicates that this pupil behaves as described "rarely", if at all. A rating of "5" indicates this pupil behaves as described "almost always". Ratings of "2", "3" and "4" are intermediate ratings along this frequency continuum.

		Rarely				Almost Always
1.	Works on assigned tasks.	(1)	(2)	(3)	(4)	(5)
2.	Completes assignments.	(1)	(2)	(3)	(4)	(5)
3.	Accurately follows written or printed directions	(1)	(2)	(3)	(4)	(5)
4.	Adapts readily to change (in direction, task, situation)	(1)	(2)	(3)	(4)	(5)
5.	Becomes distracted by normal classroom activity.	(1)	(2)	(3)	(4)	(5)
6.	Attends, listens to persons presenting information	(1)	(2)	(3)	(4)	(5)
7.	Expresses positive feelings about school	(1)	(2)	(3)	(4)	(5)
8.	Identifies main ideas presented in reading materials	(1)	(2)	(3)	(4)	(5)
9.	Identified letters of alphabet	(1)	(2)	(3)	(4)	(5)
10.	Makes appropriate sound-symbol relationships	(1)	(2)	(3)	(4)	(5)
11.	Exhibits ability to identify body parts and functions.	(1)	(2)	(3)	(4)	(5)
12.	Responds accurately to questions on basic concepts, e.g., color, size, direction	(1)	(2)	(3)	(4)	(5)

Teachers' Rating Scale for Pupil Behavior (Continued) FORM A

13.	Exhibits ability to pick out one idea, word or picture from a large background.	(1)	(2)	(3)	(4)	(5)
14.	Becomes confused when identifying or writing letters of different direction, but similar shape, e.g., b-d, p-q, n-u	(1)	(2)	(3)	(4)	(5)
15.	Relates events in a naturally occurring order	(1)	(2)	(3)	(4)	(5)
16.	Substitutes gestures or noises for verbal expression.	(1)	(2)	(3)	(4)	(5)
17.	Mispronounces some speech sounds.	(1)	(2)	(3)	(4)	(5)
18.	Has dysfluent speech e.g., repeats sounds, words; crowds words together.	(1)	(2)	(3)	(4)	(5)
19.	Has unusual voice, i.e., loud, harsh, soft, with frequent breaks or nasality.	(1)	(2)	(3)	(4)	(5)
20.	Has unusual mannerisms consistently accompanying speech, e.g., blinking eyes, snapping fingers or nodding head.	(1)	(2)	(3)	(4)	(5)
21.	Uses phrases or single words in place of complete sentences	(1)	(2)	(3)	(4)	(5)
22.	Makes appropriate use of plurals and possessives while speaking	(1)	(2)	(3)	(4)	(5)
23.	Exhibits self-control when necessary.	(1)	(2)	(3)	(4)	(5)
24.	Seeks extra attention during regular classroom activities	(1)	(2)	(3)	(4)	(5)
25.	Displays sadness.	(1)	(2)	(3)	(4)	(5)
26.	Expresses trust for people and the physical environment	(1)	(2)	(3)	(4)	(5)
27.	Expresses feelings of inferiority	(1)	(2)	(3)	(4)	(5)
28.	Behaves impulsively	(1)	(2)	(3)	(4)	(5)

Teachers' Rating Scale for Pupil Behavior (Continued) FORM A

29.	Accepts offers of help when needed.	(1)	(2)	(3)	(4)	(5)
30.	Is hyperactive, physically over-active.	(1)	(2)	(3)	(4)	(5)
31.	Becomes aroused to anger easily	(1)	(2)	(3)	(4)	(5)
32.	Responds slowly to or frequently asks for repetition of oral instructions.	(1)	(2)	(3)	(4)	(5)
33.	Hears conversation in group situations.	(1)	(2)	(3)	(4)	(5)
34.	Responds to oral instructions when back is turned	(1)	(2)	(3)	(4)	(5)
35.	Accurately copies work from chalkboard.	(1)	(2)	(3)	(4)	(5)
36.	Avoids work requiring concentrated visual attention	(1)	(2)	(3)	(4)	(5)
37.	Moves body in a clumsy, awkward manner (accidently breaks and tears things)	(1)	(2)	(3)	(4)	(5)
38.	Exhibits good personal and/or health habits	(1)	(2)	(3)	(4)	(5)
39.	Complains of illness, e.g., headaches, stomachaches).	(1)	(2)	(3)	(4)	(5)
40.	Responds slowly in physical motion (lethargic, sluggish).	(1)	(2)	(3)	(4)	(5)
41.	Exhibits adequate gross motor coordination, e.g., hop, skip, kick . . .	(1)	(2)	(3)	(4)	(5)
42.	Exhibits adequate fine motor coordination, e.g., writing, cutting, drawing	(1)	(2)	(3)	(4)	(5)
43.	Comes to shool late	(1)	(2)	(3)	(4)	(5)
44.	Attends school regularly.	(1)	(2)	(3)	(4)	(5)
45.	Interacts positively with peers; makes and keeps friends.	(1)	(2)	(3)	(4)	(5)

Teachers' Rating Scale for Pupil Behavior (Continued) FORM A

46. Relates to persons in authority	(1)	(2)	(3)	(4)	(5)
47. Follows rules, regulations.	(1)	(2)	(3)	(4)	(5)
48. Shares with others.	(1)	(2)	(3)	(4)	(5)
49. Asserts self in a constructive manner	(1)	(2)	(3)	(4)	(5)
50. Is bashful, reticent.	(1)	(2)	(3)	(4)	(5)
51. Acts hostile towards others	(1)	(2)	(3)	(4)	(5)
52. Damages or destroys material objects belonging to others.	(1)	(2)	(3)	(4)	(5)
53. Exhibits over dependency upon others.	(1)	(2)	(3)	(4)	(5)
54. Behaves in a manner which disrupts classroom discipline	(1)	(2)	(3)	(4)	(5)
55. Selects solitary activities	(1)	(2)	(3)	(4)	(5)

TEACHERS' RATING SCALE FOR PUPIL BEHAVIOR

Pupil's Name: _____

Rater's Name: _____

Date of Rating: _____

FORM B (Grades 4-8)

Directions: Rate this pupil's behavior from "1" to "5" for each behavioral description by placing an "X" on the selected numeral. A rating of "1" indicates that this pupil behaves as described "rarely", if at all. A rating of "5" indicates this pupil behaves as described "almost always". Ratings of "2", "3" and "4" are intermediate ratings along this frequency continuum.

		Rarely				Almost Always
1.	Works on assigned tasks	(1)	(2)	(3)	(4)	(5)
2.	Completes assignments	(1)	(2)	(3)	(4)	(5)
3.	Accurately follows written or printed directions	(1)	(2)	(3)	(4)	(5)
4.	Adapts readily to change (in direction, task, situation)	(1)	(2)	(3)	(4)	(5)
5.	Becomes distracted by normal classroom activity	(1)	(2)	(3)	(4)	(5)
6.	Attends, listens to persons presenting information	(1)	(2)	(3)	(4)	(5)
7.	Expresses positive feelings about school	(1)	(2)	(3)	(4)	(5)
8.	Identifies main ideas presented in reading materials	(1)	(2)	(3)	(4)	(5)
9.	Makes appropriate sound-symbol relationships	(1)	(2)	(3)	(4)	(5)
10.	Recognizes word meanings from context	(1)	(2)	(3)	(4)	(5)
11.	Uses effective study procedures	(1)	(2)	(3)	(4)	(5)
12.	Mispronounces some speech sounds	(1)	(2)	(3)	(4)	(5)

Teachers' Rating Scale for Pupil Behavior (Continued) FORM B

13. Has dysfluent speech, e.g., repeats sounds, words; crowds words together	(1)	(2)	(3)	(4)	(5)
14. Has unusual voice, i.e., loud, soft, harsh, with frequent breaks or nasality	(1)	(2)	(3)	(4)	(5)
15. Has unusual mannerisms consistently accompanying speech, e.g., blinking eyes, snapping fingers, or nodding head	(1)	(2)	(3)	(4)	(5)
16. Uses phrases or single words in place of complete sentences	(1)	(2)	(3)	(4)	(5)
17. Makes appropriate use of plurals and possessives when speaking	(1)	(2)	(3)	(4)	(5)
18. Uses oral language to express thoughts or ideas	(1)	(2)	(3)	(4)	(5)
19. Substitutes gestures or noises for verbal expression	(1)	(2)	(3)	(4)	(5)
20. Exhibits self control when necessary	(1)	(2)	(3)	(4)	(5)
21. Becomes frustrated easily	(1)	(2)	(3)	(4)	(5)
22. Exhibits behavior associated with daydreaming	(1)	(2)	(3)	(4)	(5)
23. Responds negatively to people and situations	(1)	(2)	(3)	(4)	(5)
24. Becomes easily embarrassed, self-conscious	(1)	(2)	(3)	(4)	(5)
25. Becomes easily hurt (feelings)	(1)	(2)	(3)	(4)	(5)
26. Exhibits nervous habits, mannerisms	(1)	(2)	(3)	(4)	(5)
27. Exhibits self-reliant behavior	(1)	(2)	(3)	(4)	(5)
28. Displays odd or bizarre behavior	(1)	(2)	(3)	(4)	(5)
29. Responds slowly to or frequently asks for repetition of oral directions	(1)	(2)	(3)	(4)	(5)
30. Hears conversation in group situations	(1)	(2)	(3)	(4)	(5)

Teachers' Rating Scale for Pupil Behavior (Continued) FORM B

31. Accurately copies work from chalkboard	(1)	(2)	(3)	(4)	(5)
32. Avoids work requiring concentrated visual attention.	(1)	(2)	(3)	(4)	(5)
33. Has good posture	(1)	(2)	(3)	(4)	(5)
34. Complains of illness, e.g., headaches, stomachaches.	(1)	(2)	(3)	(4)	(5)
35. Tires easily	(1)	(2)	(3)	(4)	(5)
36. Acts sleepy, drowsy.	(1)	(2)	(3)	(4)	(5)
37. Exhibits adequate motor coordination	(1)	(2)	(3)	(4)	(5)
38. Gets to school on time	(1)	(2)	(3)	(4)	(5)
39. Attends school regularly	(1)	(2)	(3)	(4)	(5)
40. Interacts positively with peers; makes and keeps friends	(1)	(2)	(3)	(4)	(5)
41. Skips classes.	(1)	(2)	(3)	(4)	(5)
42. Chooses friends outside age group.	(1)	(2)	(3)	(4)	(5)
43. Shows leadership qualities	(1)	(2)	(3)	(4)	(5)
44. Is reported by others as being reliable, dependable.	(1)	(2)	(3)	(4)	(5)
45. Initiates positive interaction with others	(1)	(2)	(3)	(4)	(5)
46. Abuses others physically	(1)	(2)	(3)	(4)	(5)
47. Behaves in a manner which disrupts classroom discipline.	(1)	(2)	(3)	(4)	(5)
48. Makes and keeps committments to others	(1)	(2)	(3)	(4)	(5)

CHILD STUDY CENTER

A Narrative Report

CSC

EC103757

CHILD STUDY CENTER

Introduction

The Child Study Center (CSC) is a pupil services program designed to meet the needs of educationally troubled children. The purpose of the Center is to deliver the diagnostic, prescriptive and consultative intervention necessary to assist referred children experience success in school and at home.

CSC is staffed by an interdisciplinary team to serve the whole child in a single referral setting. CSC embraces the disciplines of education, psychology, social work, and speech pathology with consultation from medical and other community professionals.

Major activities of the Center include: conducting an in-depth, comprehensive study of each participating child; developing composite diagnoses and prescriptions for establishing remedial plans; providing short-term diagnostic treatment for determining the validity of diagnostic and prescriptive reports; and conducting activities to facilitate adequate implementation of prescribed treatment plans. The exchange of information and the active cooperation among CSC, school, home and community resources is the key to providing services which help referred children overcome learning problems and experience new successes.

A brief description of data collection, evaluation, consultation and remediation processes highlighted in the CSC brochure follow.

Data Collection

Data collection activities by various Child Study Center (CSC) staff are a crucially important aspect of the entire study of the child. Since learning problems have multiple causations, it is necessary to gather information that relates to all facets of the learning process. Upon receipt of a referral signed by the principal, an intake conference is arranged with the parents to further define the nature of the child's problems. Also, the CSC team assigns a staff member to coordinate the collection of preliminary data which is obtained from student records, school personnel and community professionals. A major thrust is made to incorporate reports from all persons who have provided special services for the child. Thus, coordinating the delivery of services with medical and other community personnel is an integral part of the data collection process.

Since the behaviors of a child in a classroom, at home and in a controlled one-to-one situation may vary radically, it is important to have information about how a child functions in each environment. The teachers' reported perceptions of a child's behavior at school provide insight into an understanding of the child's problems as well as the nature of teacher-child relationships. Information from parents is essential and may vary from the teachers' descriptions of the child and CSC observations of manifest behaviors.

Packets describing data collection procedures and forms are available upon request.

Evaluation

The diagnostic study of the referred child encompasses intellectual, educational, physical, social, familial, emotional and communication factors that primarily affect learning. Formal evaluation time ranges from 4 to 12 hours. Typically, the social work intake precedes direct diagnostic evaluation of the child. Scheduling the child for 3 successive mornings for diagnostic studies has been a preferred operational strategy. Additional evaluations and community contacts are arranged as need indicates.

The evaluative function is the heart of the program for Center personnel and consumes an intensity of effort, if not a major portion of time. Following individual diagnostic activities, team staffings and consultations are scheduled to synthesize the results of individual specialists into a composite whole. Although comprehensive, the composite reports are not all inclusive. Rather, they are designed to pin-point specific problems, relating directly to learning skills and behavior patterns, and to develop strategies by which parents, teachers and others can intervene successfully. The diagnostic findings are reported to school personnel and parents in person and in writing.

A list of evaluation activities and resources has been compiled by the educational diagnosticians, psychologist and speech pathologist of the CSC team.

Consultation

Consultation is an ongoing process within the team, with parents and with school and community professionals. The case coordinator bears the burden of keeping things moving by involving significant persons at appropriate times.

Effective communication and collaboration are fundamental to the success of all CSC operations. Diagnostic findings and prescriptive recommendations become useful only when they are meaningful and acceptable to all those who educate the child. Consultation sessions serve various purposes. For example, consultations are scheduled for pre-referral, crisis, short-term intervention, medical, follow-up and other situational variables. Consultation may involve one or more Center staff members with teachers, Pupil Personnel workers, community agency personnel, supplementary school personnel and medical personnel. Two of the most important consultative efforts include (1) consultation among Center staff and involved school personnel during and following the Center study to discuss findings and plans for the child and (2) consultation with the child's parents to maintain their support and involvement.

A report delineating conceptual approaches and practical guidelines for successful consultation is being prepared by CSC staff for dissemination.

Remediation

Remedial efforts are designed to assist the child improve his learning and communication skills as well as increase his frequency of productive social behavior. A major objective of CSC is to monitor and modify the learning process so the child can individuallly experience feelings of success at school and home. In addition to remediation in academic and communication skill areas, individual or group counseling for children and/or their parents by Center staff enhances the child's motivation to learn and behave more productively.

Facilitating the implementation of prescribed activities is a major concern. Historically, persons requesting intervention absolved themselves of further involvement to the extent that the problems of the referred child were frequently viewed as the sole responsibility of the referral resource. The Child Study Center constructively confronts this problem by delineating the purpose and responsibilities of CSC, involving adults in a position to help at all stages of intervention and collaborating with school, home and community resources in developing specific plans of action for assisting referred children.

Remediation strategies for selected learner problems are being packaged for dissemination.

Demonstration

We are anxious to demonstrate our program and discuss what we have learned in developing and implementing the Child Study Center program during the past three years.

Additional materials and displays are being prepared to describe and demonstrate Child Study Center program components. Reports are available for potential adopters which summarize cost information, evidence of success and portability factors. Visitations at the demonstration center are encouraged and workshops or program presentations can be exported by Child Study Center team members.

Please indicate below those areas in which you would wish to receive additional information and mail to:

Dr. Ralph E. Bailey, Director
Pupil Personnel Services Demonstration Project
All Children's Hospital, C-2
801 6th Street South
St. Petersburg, Florida 33701

Please send me the following information about the Child Study Center program.

( ) Evaluation Instruments & Methodology
( ) Data Collection Forms & Processes
( ) Consultation: Conceptual Approaches and Practical Guidelines
( ) Remediation Strategies for Selected Learner Problems
( ) Potential Adopter's Report: Costs, Effectiveness, Portability

My Mailing Address is: _____

_____

_____

_____

CHILD STUDY CENTER

An Innovation of the Pupil Personnel Services Demonstration Project

DIANA BRYANT, Educational Diagnostician

LINDA LEEPER, Speech Pathologist

ANN LYONS, Social Worker

OLETA PAYNE, Educational Diagnostician

DON WAKELING, Psychologist

ELAINE WHEELER, Secretary

SCHOOL BOARD OF PINELLAS COUNTY, FLORIDA
Rev. Arthur L. Albers, Chairman
Gus Sakkis, Superintendent

Validated for National Dissemination
ESEA Title III

SYNTHESIS

CSC

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The Child Study Center (CSC) is a validated Pupil Services program which assists students with learning problems achieve significant gains in intellectual performance, basic skill acquisition and personal/social functioning. CSC embraces the disciplines of education, psychology, social work and speech pathology with consultation from medical and other community professionals.

CSC is an innovation of the
Pupil Personnel Services Demonstration Project, ESEA Title
School Board of Pinellas County, Florida
Gus Sakkis, Superintendent

EC 103757

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- OBSERVATION of CHILD IN CLASS
- STUDY OF ALL SCHOOL RECORDS
- DATA ON ANY PREVIOUS SERVICE

Teacher's Description | Medical Background | Parent Intake

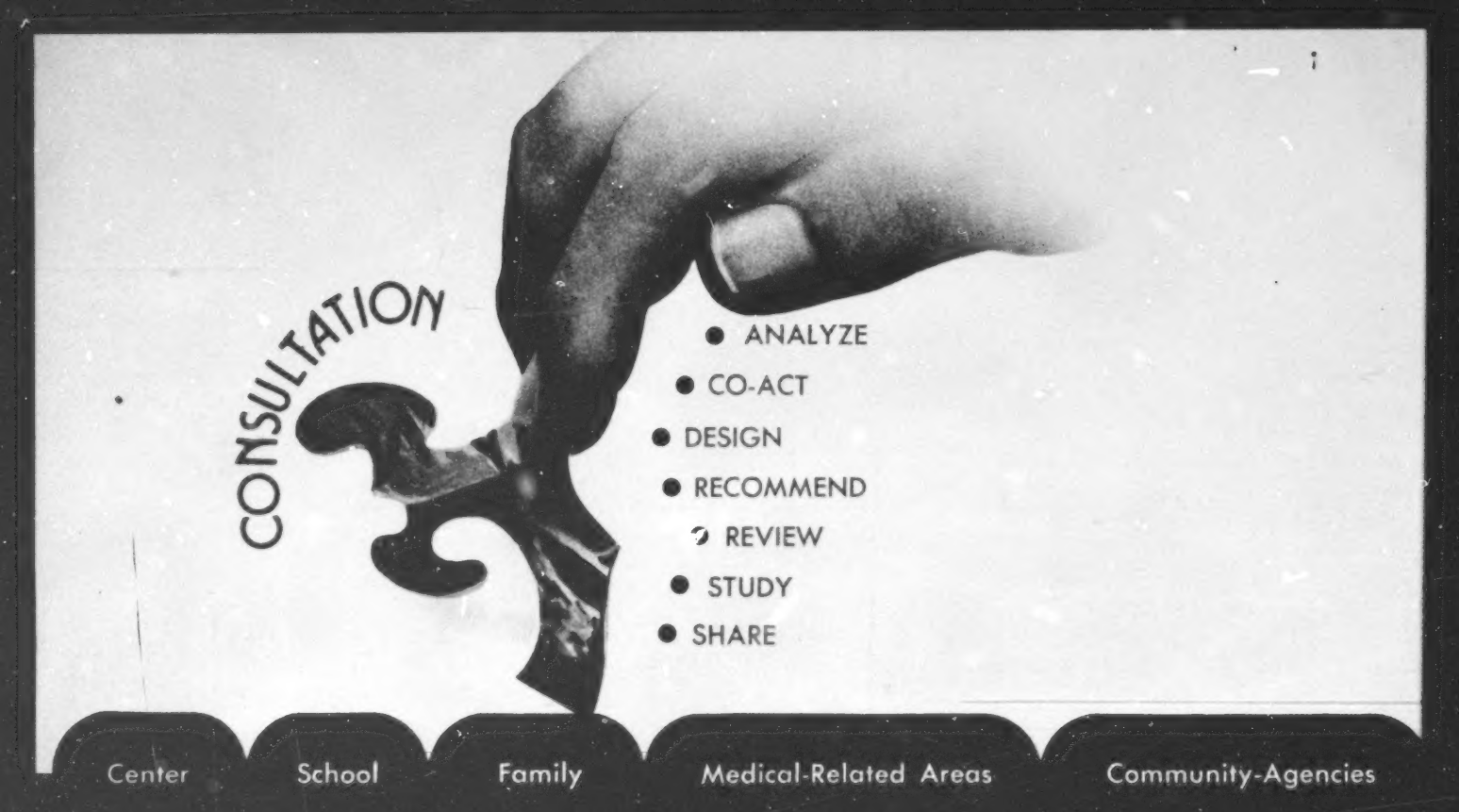
EVALUATION ACTIVITIES

- COMMUNICATION
- INTELLECTUAL
- LEARNING
- MEDICAL-RELATED AREAS
- SOCIAL-EMOTIONAL

Diagnostic Teaching

Behavioral Observation

Parent Conferences

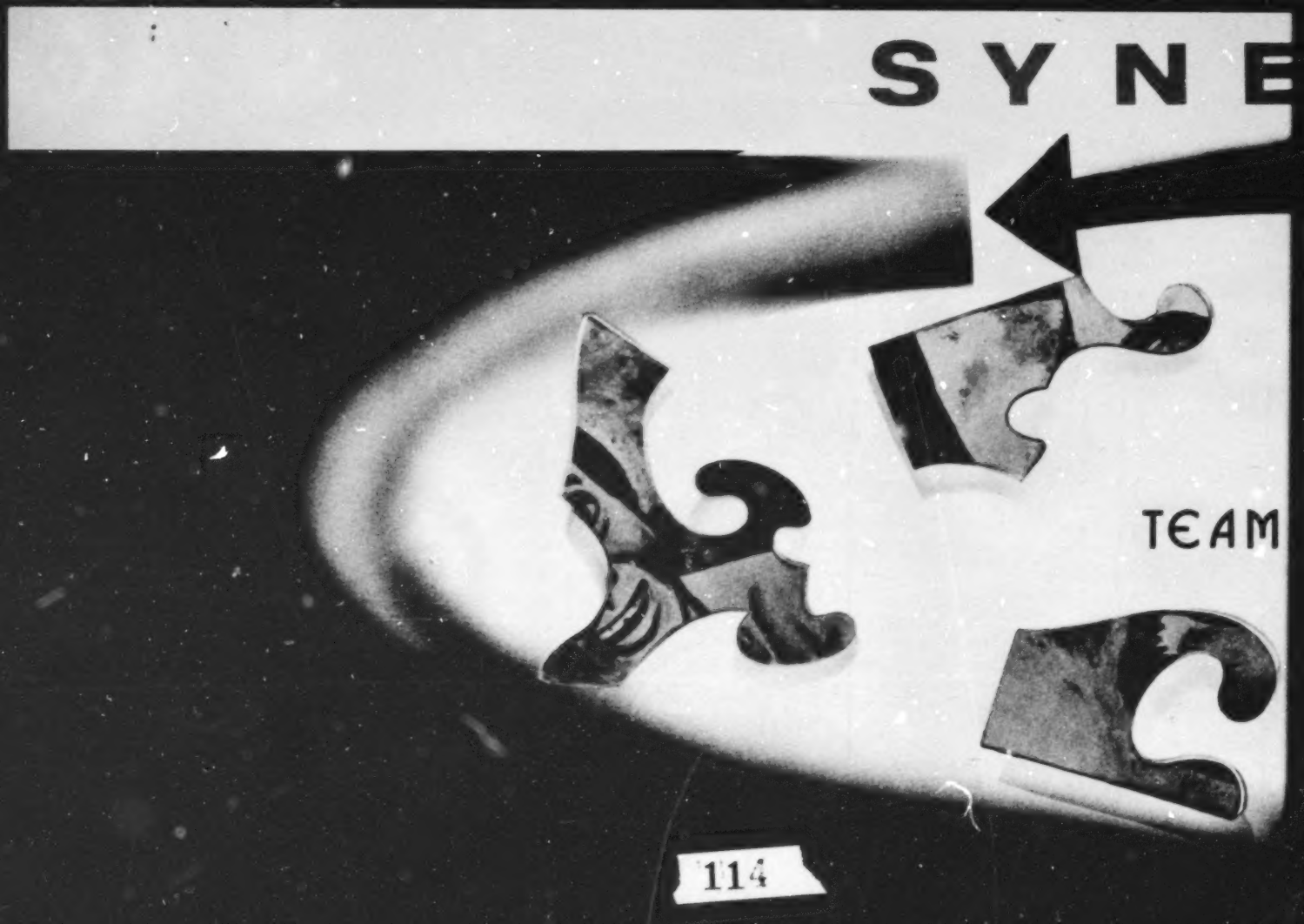

CONSULTATION
ANALYZE
CO-ACT
DESIGN
RECOMMEND
REVIEW
STUDY
SHARE
Center
School
Family
Medical-Related Areas
Community-Agencies

- COUNSEL
- EDUCATE
- IMPLEMENT
- RECLAIM
- REFER
- REVERSE

Pupil | Teacher-Tutor | Special Resources | Parent

- CLARIFY
- ILLUSTRATE
- DISPLAY
- EXPLAIN
- INVOLVE
- REFLECT

Audio-Visual Programs | Critical Use of New Materials | Workshop Participations | Case Studies | Observation Sessions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TEAM
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R G I S M

CHILD STUDY CENTER

For more information contact:
Dr. Ralph E. Bailey, Director
Pupil Personnel Services Demonstration Project
All Children's Hospital, C-2
801 6th Street South
St. Petersburg, Florida 33701
(813) 821-5260

SYNTHESIS